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1976

SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

# National Health Insurance Resource Book

## REVISED EDITION

AUGUST 30, 1976

*Prepared by the Staff of the*
**COMMITTEE ON WAYS AND MEANS**
*for the use of the Committee*

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# LETTER OF TRANSMITTAL

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CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., August 30, 1976.*

Hon. AL ULLMAN,
*Chairman, Committee on Ways and Means,*
*U.S. House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: I am pleased to present to the Committee on Ways and Means a revised edition of the National Health Insurance Resource Book. The first edition of this study, published on April 11, 1974, has proven to be invaluable to the committee in its consideration of national health insurance. The Resource Book has also been widely used by individuals and organizations who have need for a comprehensive reference work on national health insurance and the health care system of the United States. The staff has therefore updated and revised the Resource Book to provide the most current possible information.

As in the first edition, the study is organized so that any particular subject can be explored in considerable depth or given just a general review: the extensive tables make the book useful as a general reference source for many purposes.

> Part I presents an overview of the major characteristics of the health industry, through the use of charts and tables as well as brief textual material.
>
> Part II generally follows the organization of part I and presents textual material in considerable detail. At the end of each chapter is a set of detailed tables which can be used to answer questions not addressed directly in the textual material.
>
> Part III presents information on the health financing and delivery systems of selected foreign nations. The material on Canada is in considerably more detail than that presented for other nations since the Canadian experience seems more relevant to U.S. policy.
>
> Part IV presents information about existing health-related activities under the jurisdiction of the Committee on Ways and Means—the medicare program, Professional Standards Review Organizations, and the Federal income tax treatment of health-related expenditures.
>
> Part V presents descriptions of major bills on the subject of national health insurance introduced in this Congress, to date.

Once again, it is appropriate to recognize with great appreciation the contributions to this book made by individuals in the Education and Public Welfare Division (health section) of the Congressional Research Service, particularly the efforts of Susan Bailey, Kay Cavalier, Jack Ebeler, Edward Klebe, Janet Kline, Robert Hoyer, Glenn Markus, Jennifer O'Sullivan, and Richard Price.

Sincerely yours,

DAN ROSTENKOWSKI,
*Chairman, Subcommittee on Health.*

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# PART I

# Key Facts on the Health Industry

The material that follows presents in chart and brief narrative form the major characteristics of the American health industry. It should be especially useful for the reader who wishes to gain a quick overview of this complex industry. The next part of the book covers substantially the same ground, but does so in some depth.

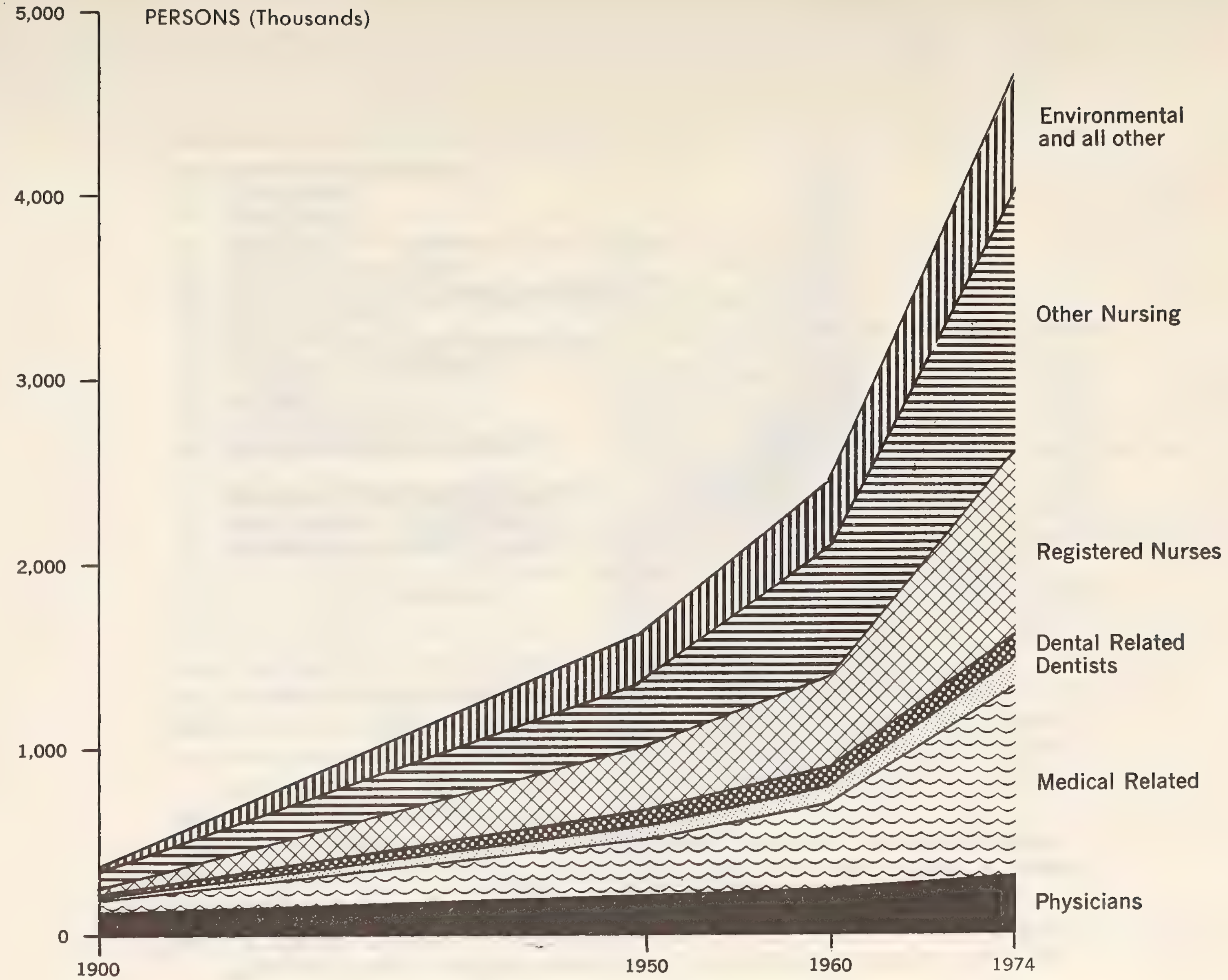
# Chapter 1. General Information on the Health Industry

## CHART 1a.—*Health is the third largest industry in the United States, employing 4.7 million people*

The health care industry encompasses a wide variety of institutions, organizations, and personnel that provide the full gamut of medical, therapeutic, and related services to the 200-plus million persons in the United States. More specifically, these services include prevention, detection, treatment, rehabilitation, research, training, and capital investment in medical facilities. They are financed through a mixture of private and Federal, State, and local government funds.

The health care field in 1960 was the third largest U.S. industry, employing 2.5 million persons. By 1974, the number employed in that field rose to an estimated 4.7 million persons an increase of 88 percent or over 2 million persons above the 1960 level.

Since the turn of the century, the supply of health manpower has increased about twelvefold. The most noticeable trend has been the development of new health occupations resulting from increased demand for health services, improved medical technology, and other advances. There has been a sharp decline in the ratio of physicians to all health personnel because of relatively small numerical increases in physicians so far in this century. Steadily increasing numbers of registered nurses and other medical-related personnel have largely accounted for the overall growth of the health labor force to its present size.



Source: Pennell, Maryland Y., and Hoover, David B., *Health Manpower Source Book*, Sec. 21. Public Health Service Publication No. 263, U.S. Department of Health, Education, and Welfare, 1970.

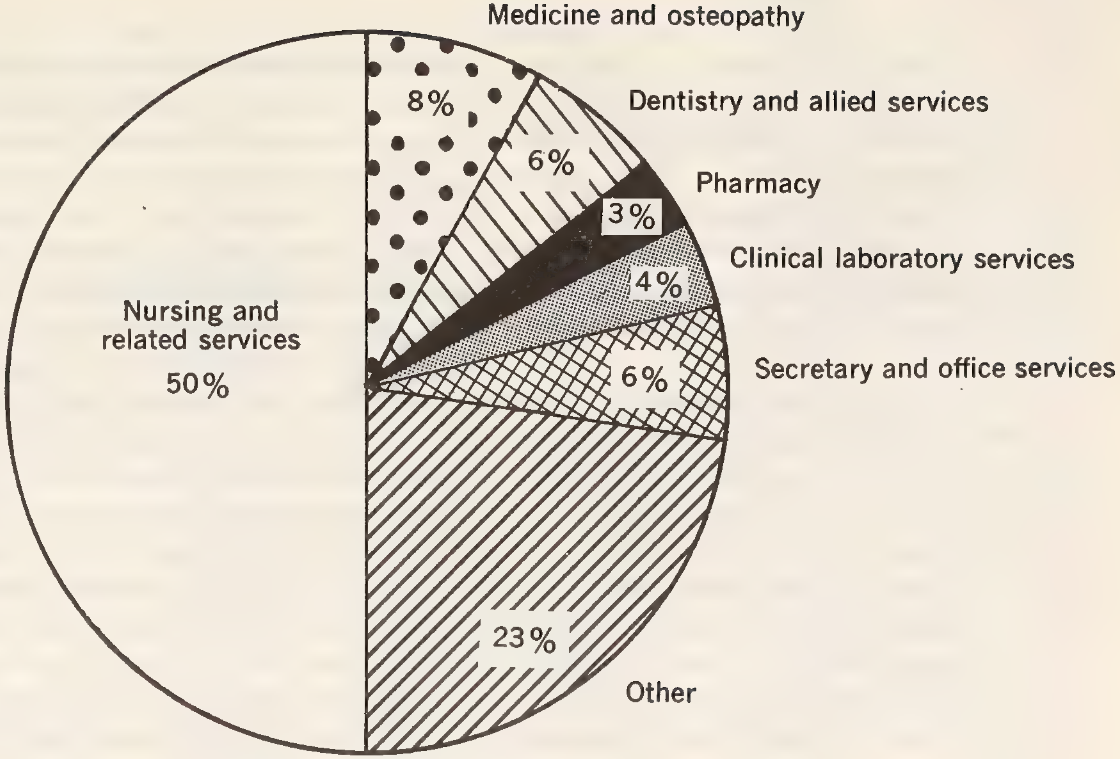
*Health Resources Statistics, 1975*. Public Health Service, U.S. Department of Health, Education, and Welfare.

## CHART 1b.—*Half of all health care personnel provide nursing-related services*

The more than 2.3 million nurses, aides, and orderlies made up 50 percent of the Nation's health manpower in 1974—by far its largest component. Physicians and dentists (including dental assistants) comprised about 14 percent of the total. The remaining 36 percent were employed in over 30 other skilled and unskilled health-related occupations. Altogether, about three-fifths of the health personnel were employed by hospitals.

The health care industry figures used here, though broad in scope, exclude millions of workers in occupations associated directly or indirectly with the health care field, such as the manufacture of drugs. The following list includes the 14 major health occupations, the number of persons employed in each in 1974, and the proportion of total health manpower each represents:

| Occupation | Number | Percent of total |
|---|---|---|
| 1. Nursing and related services | 2,319,000 | 50 |
| 2. Medicine and osteopathy | 362,700 | 8 |
| 3. Secretarial and office services | 275,000–300,000 | 6 |
| 4. Dentistry and allied services | 279.800 | 6 |
| 5. Clinical laboratory | 172,500 | 4 |
| 6. Pharmacy | 132,900 | 3 |
| 7. Radiologic technology | 100,000 | 2 |
| 8. Dietetic and nutritional service | 72,200 | 2 |
| 9. Medical records | 60,000 | 1 |
| 10. Administration of health services | 48,200 | 1 |
| 11. Medical social work | 38,600 | 1 |
| 12. Optometry, opticianry, and ocular services | 37,100<br>37,300 | 1 |
| 13. Psychology | 35,000 | 1 |
| 14. Veterinary medicine | 33,500 | 1 |



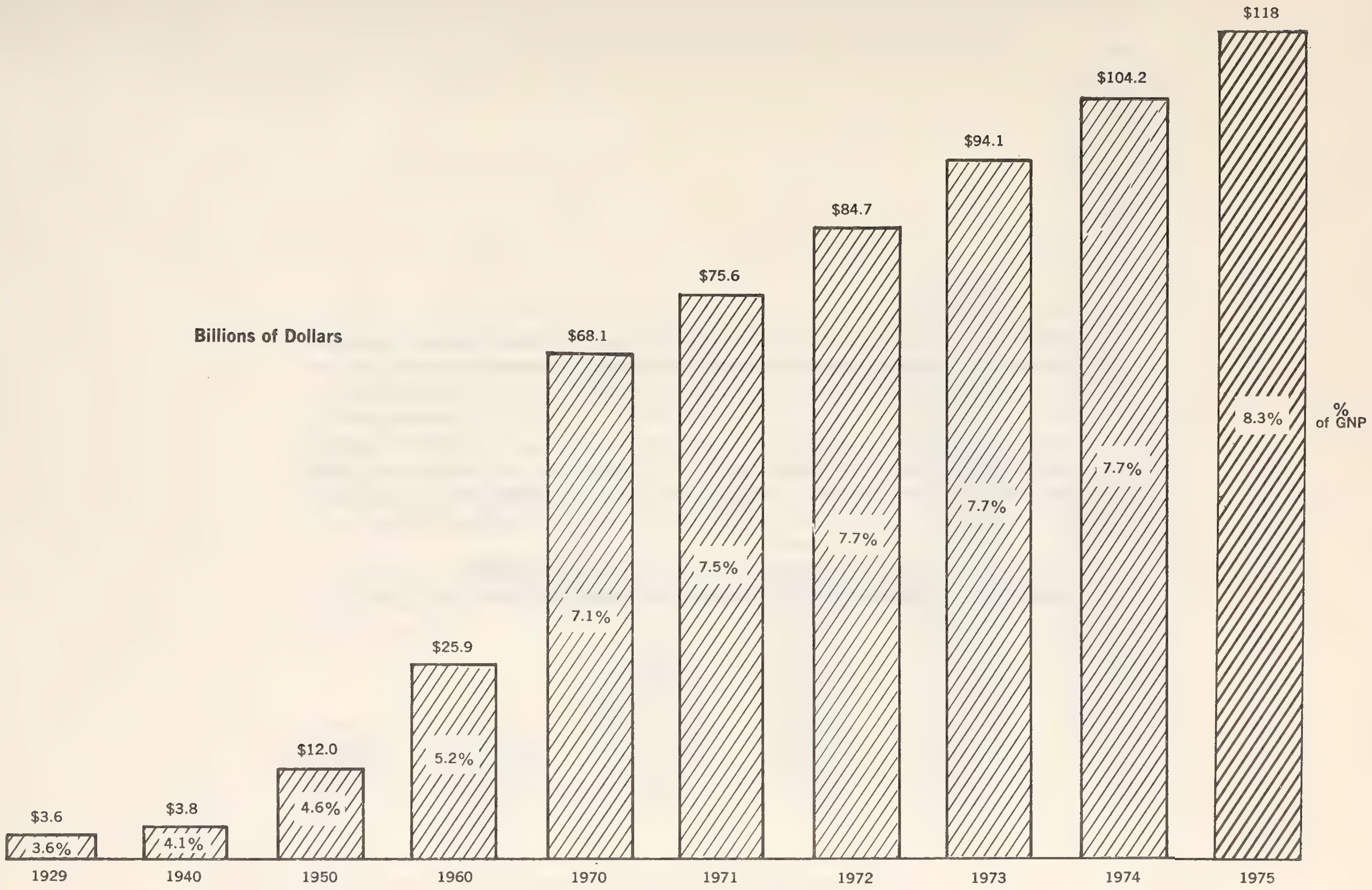
**Total: 4.7 million workers**

Source: *Health Resources Statistics, 1975*, Public Health Service, U.S. Department of Health, Education, and Welfare.

## CHART 1c.—*Health spending today—$118.5 billion—is 10 times the spending of 25 years ago*

The past few years have witnessed sharp increases in the amounts spent for medical care. In fiscal 1975, this Nation spent $118.5 billion for health and medical care—4.6 times the amount spent in 1960 and nearly 10 times the amount spent in 1950. Growth in medical care spending has outdistanced that of the economy in general. In fiscal year 1950, medical care expenditures totaled $12.0 billion and represented 4.6 percent of the gross national product (the total market value of the Nation's annual output of goods and services). By fiscal 1960 their share of the gross national product (GNP) had reached 5.2 percent. The acceleration in health spending in 1975 coupled with a slowed growth in the GNP resulted in a significant increase its share of the GNP—from 7.7 in 1974 to 8.3 percent in 1975.

Part of the increasing share of GNP attributable to health is due to the higher prices for medical care compared with other items. There has also been an increased demand for health services resulting from population growth generally, rising per capita incomes, and growth of private health insurance and prepayment plans. Additional contributing factors include a rising proportion of elderly in the population, higher educational levels, a shift from acute illnesses to more expensive long-term illnesses, introduction of new medical techniques and procedures to treat conditions that formerly could not be treated at all, and finally, the growing awareness of the benefits of medical care.

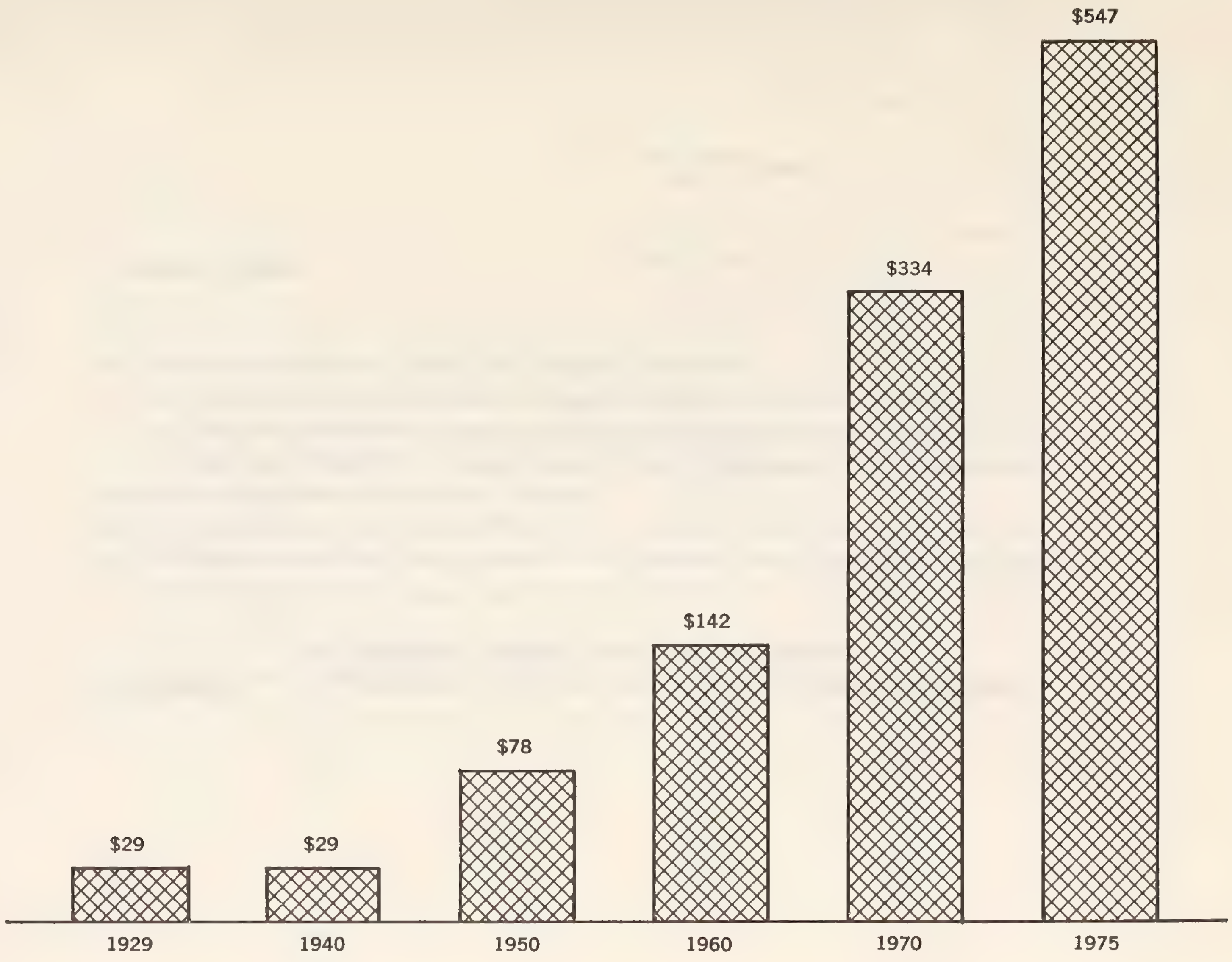


Source: Mueller, Marjorie Smith and Robert M. Gibson. "National Health Expenditures, Fiscal Year 1975." *Social Security Bulletin*, February 1976, U.S. Department of Health, Education, and Welfare.

## CHART 1d.—*In the past two decades, each person's average health bill has grown from $78 to $547*

In fiscal 1975, the average health bill for each American was $547. In 1960, the average health bill was about a fourth that amount—$142—and in 1950, it was less than one-seventh the 1975 amount. This growth, from $78 in 1950 to $547 in 1975, represents about a 600-percent increase over the 25-year period.

Included in the total personal health bill are payments for health care services under government programs, private health insurance payments, voluntary health giving, and direct payments for health care by individuals.

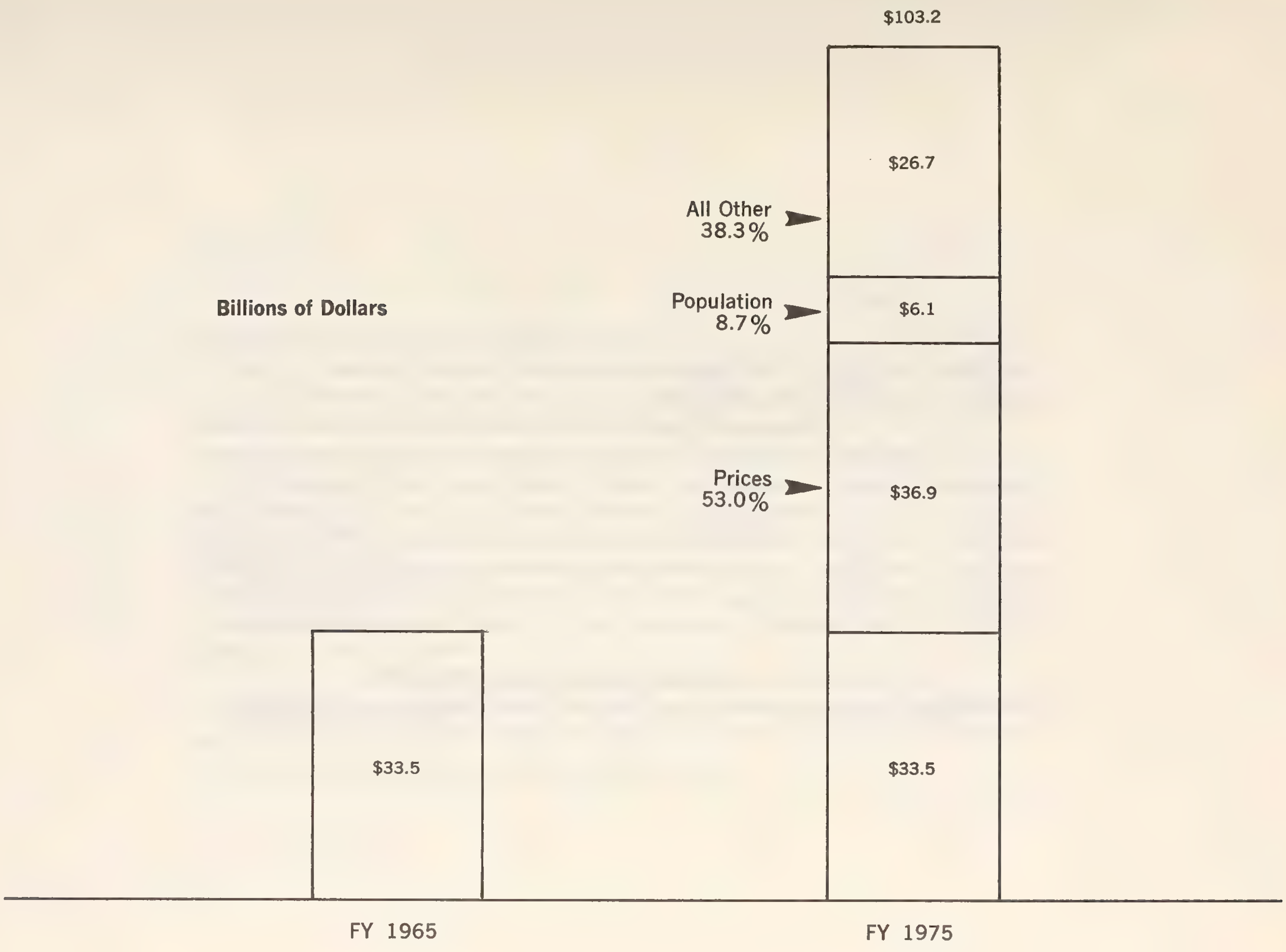


Source: Mueller, Marjorie Smith and Robert M. Gibson. "National Health Expenditures, Fiscal Year 1975." *Social Security Bulletin*, February 1976, U.S. Department of Health, Education, and Welfare.

## CHART 1e.—*Higher prices caused over half the 10-year growth in personal health care expenditures*

During the period 1965–1975, personal health care expenditures (those for the direct benefit of the individual, e.g., hospital care, physicians' services) rose by $70 billion. The spiraling increases in such expenditures during that period resulted from three major factors:

- Fifty-three percent, or $36.9 billion, can be attributed to price increases.
- Another 9 percent, or $6.1 billion, results from population growth.
- The remaining 38 percent, or $26.7 billion, is due to increased use of services and the introduction of new medical techniques.



Source: Mueller, Marjorie Smith and Robert M. Gibson. "National Health Expenditures, Fiscal Year 1975." *Social Security Bulletin*, February 1976, U.S. Department of Health, Education, and Welfare.

## CHART 1f.—*Medical care prices have accelerated rapidly since the Economic Stabilization Act expired*

Recent inflationary trends in the economy in general, and for medical care in particular, are a major concern today. The following table compares annual rates of change for selected components of the Consumer Price Index during 3 periods: (a) the 2 years preceding the Economic Stabilization Program (FY 1969–71), (b) the ESP period (August 1971 through April 1974), and (c) the cumulative post-ESP period (April 1974–February 1976). Mandatory controls were in effect for the health industry throughout the ESP period, but were not continuously in effect for the rest of the economy.

A slowdown in medicare care prices was recorded under the ESP compared to the FY 1969–71 period. During the post-ESP period, medical prices accelerated rapidly, rising faster than the overall CPI.

| Item | Annual rate of change during— | | |
|---|---|---|---|
| | Prefreeze period fiscal years 1969–71 | Economic stabilization program, August 1971–April 1974 | Post-ESP period, April 1974–February 1976 |
| CPI, all items | 5.6 | 6.4 | 8.5 |
| Less medical care | 5.5 | 6.5 | 8.3 |
| CPI, all services | 7.4 | 5.1 | 10.0 |
| Less medical care | 7.4 | 5.2 | 9.5 |
| Medical care, total | 6.7 | 4.3 | 11.9 |
| Hospital service charges [1] | NA | [2] 4.6 | 15.5 |
| Physicians' fees | 7.4 | 4.0 | 12.8 |
| Dentists' fees | 6.4 | 4.2 | 9.3 |
| Drugs and prescriptions | 2.0 | .7 | 7.7 |

[1] January 1972=100.

[2] Annualized rate of change based on change from January 1972 rather than November 1971.

Source: Consumer Price Index, Bureau of Labor Statistics.

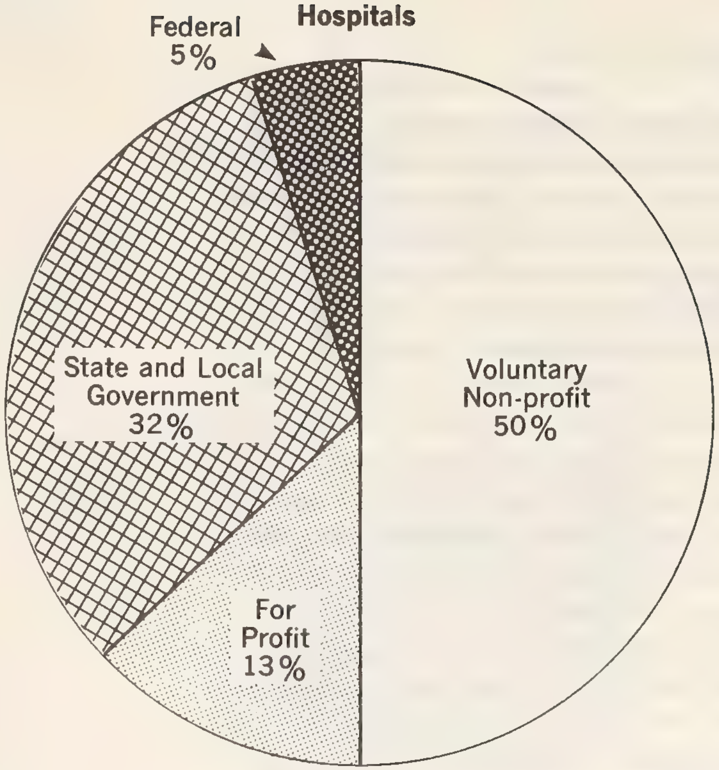
# Chapter 2. Information About Health Care Institutions

## CHART 2a.—*The hospital industry is very large and represents a mix of the public and private sectors*

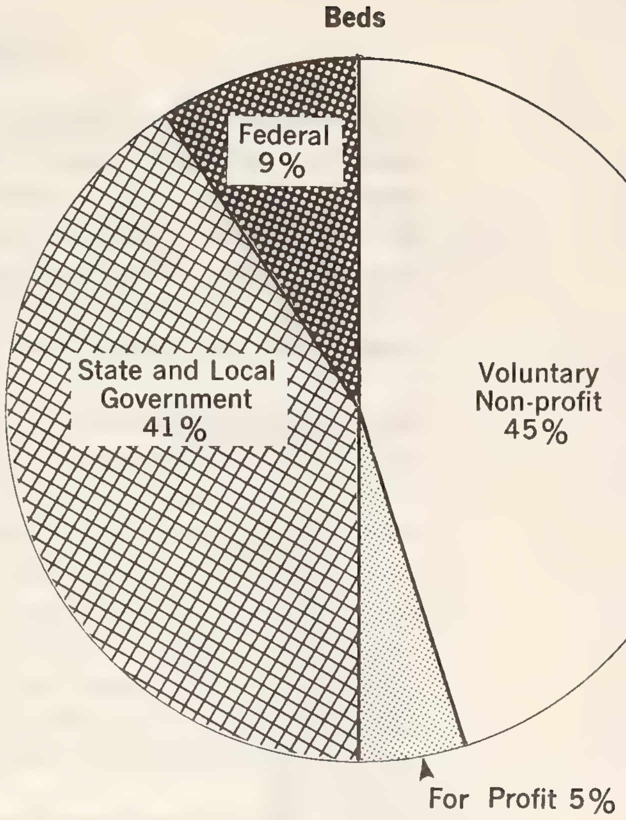
The 7,174 domestic hospitals constituted one of the Nation's largest industries in 1974 with a total capacity of 1.5 million beds and overall assets over $51.7 billion. As a rough measure of this industry's output, hospitals handled some 35.5 million admissions and more than 250 million outpatient visits at a total cost of more than $41.4 billion. They employed more than 2.9 million full-time equivalent employees with a total payroll of more than $23.8 billion.

The hospital industry represents a mix of both the public and private sectors. Thirty-seven percent of all hospitals are publicly owned; they supply 50 percent of the bed capacity in the Nation's domestic hospitals. Federal hospitals are the largest in size, followed in ranking by State and local government, voluntary nonprofit, and for-profit hospitals.

Public hospitals receive their operating revenue from different sources. Federal hospitals and, to a lesser extent State and local government hospitals, operate largely on funds budgeted by government agencies. Private hospitals generally receive their revenue directly from the patient or from third-party payers (including private insurance carriers) and public programs such as medicare and medicaid.



Total Hospitals: 7,174



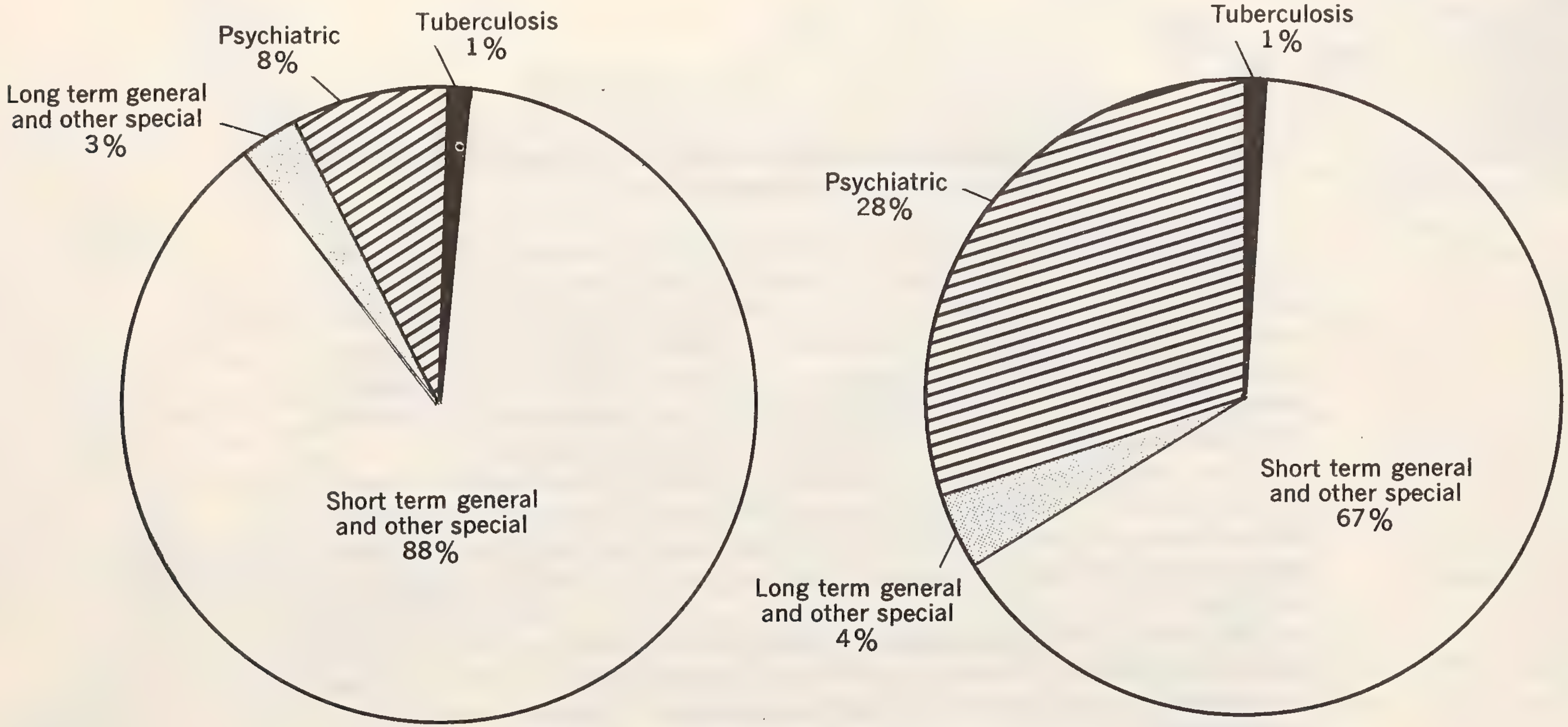
Total Beds: 1,512,684

Source: *Hospital Statistics, 1974*, American Hospital Association, 1975.

## CHART 2b.—*Hospitals specialize in the type of care provided*

U.S. hospitals can be classified into four groups representing special types of care: psychiatric, tuberculosis, short-term, and long-term general and other specials. Short-term general and other special hospitals, which contain 67 percent of all non-Federal hospital beds, provide highly intensive care for a wide range of acute disorders. Consequently, they require relatively large numbers of employees and an array of highly sophisticated equipment. Long-term care hospitals, on the other hand, are bigger units, providing much less intensive care for chronic conditions which cannot be corrected quickly. As a result, they use fewer employees and usually do not have as much of the sophisticated diagnostic and therapeutic services and equipment likely to be found in short term hospitals.

Community hospitals—all nonfederal short-term general and other special hospitals excluding units of institutions—represent the segment of the hospital industry which provides general medical care to the public as a whole. (Federal hospitals should be excluded because they are not generally accessible to the public.) Community hospitals represent over 82 percent of all hospitals, handle over 92 percent of all admissions and 75 percent of all outpatient visits, employ 78 percent of the industry's total labor force, and account for 79 percent of the total cost of hospital care.



**Hospitals 6,787**

**Beds 1,377,050**

**NON-FEDERAL HOSPITALS 1974**

Source: *Hospital Statistics, 1974,* American Hospital Association, 1975.

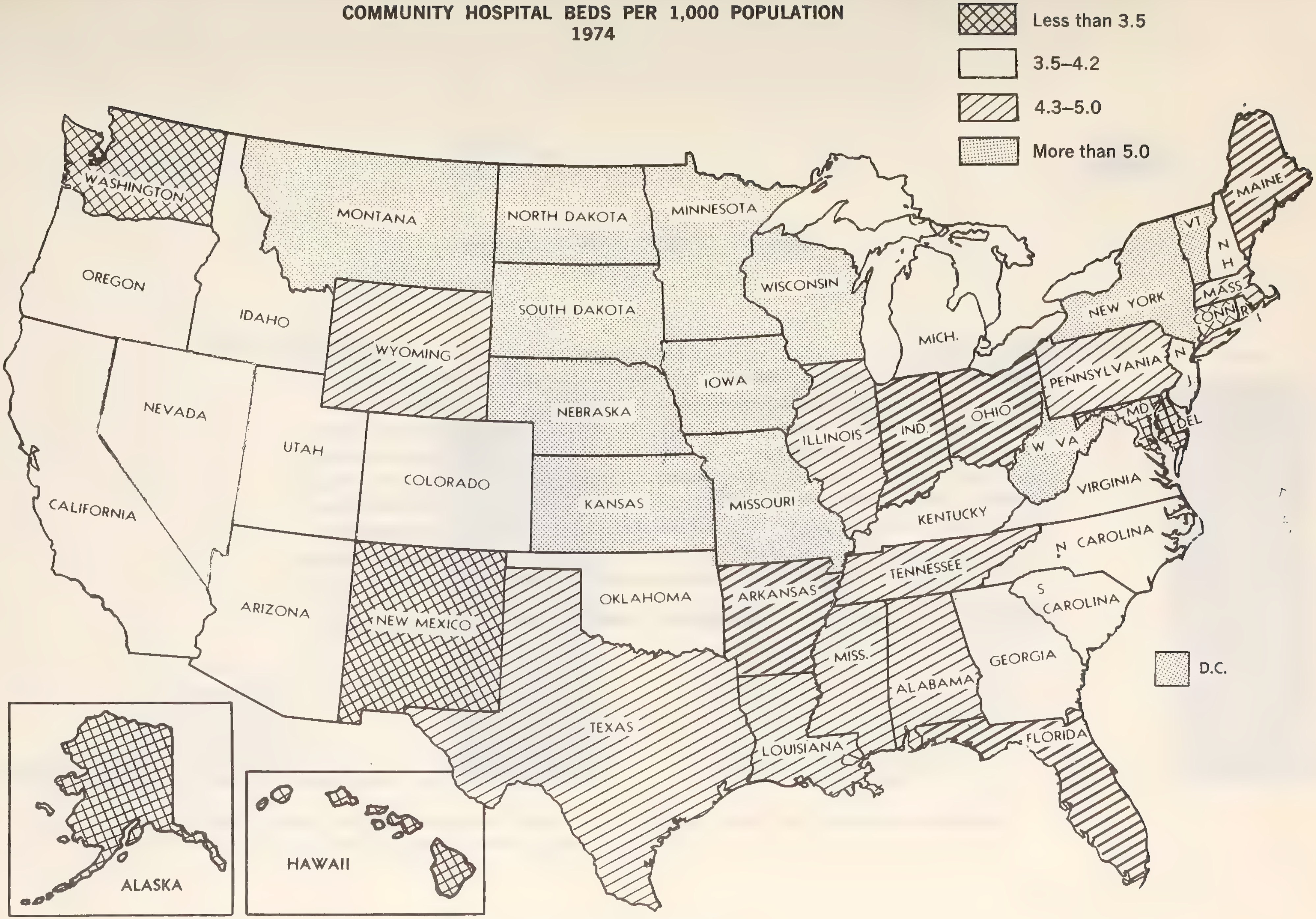
### CHART 2c.—*Considerable variation exists in the distribution of community hospital beds*

Geographically, the number of beds available in community hospitals per 1,000 population varies considerably, Hospital care is least available in Alaska (only 2 beds per 1,000 residents) and most abundant in North Dakota (6.7 beds per 1,000 residents). This variation reflects demographic characteristics of the local population, the incidence of disease, characteristics of medical practice, availability of nursing homes and other alternatives to hospital care, population density, and availability of funds for expansion.

Even though beds may be relatively abundant in some States, access to hospital care may be limited by distance to the nearest hospital, crowded facilities in some areas, and the lack of specialized care facilities such as cancer therapy units. Financial barriers to receiving care may also be an important handicap.

Although North Dakota has more hospital beds per capita than any other State, it averages less than 0.9 hospitals per 1,000 square miles. That contrasts to the average of 25 hospitals per 1,000 square miles in Massachusetts. Longer waiting periods for medical treatment may exist in some States. For example, hospital occupancy rates average 83 percent in New York but only 56 percent in Alaska.

## COMMUNITY HOSPITAL BEDS PER 1,000 POPULATION
## 1974


▩ Less than 3.5
☐ 3.5–4.2
▨ 4.3–5.0
▒ More than 5.0
WASHINGTON
OREGON
CALIFORNIA
IDAHO
NEVADA
MONTANA
WYOMING
UTAH
ARIZONA
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
MINNESOTA
IOWA
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
ILLINOIS
MICH.
IND.
OHIO
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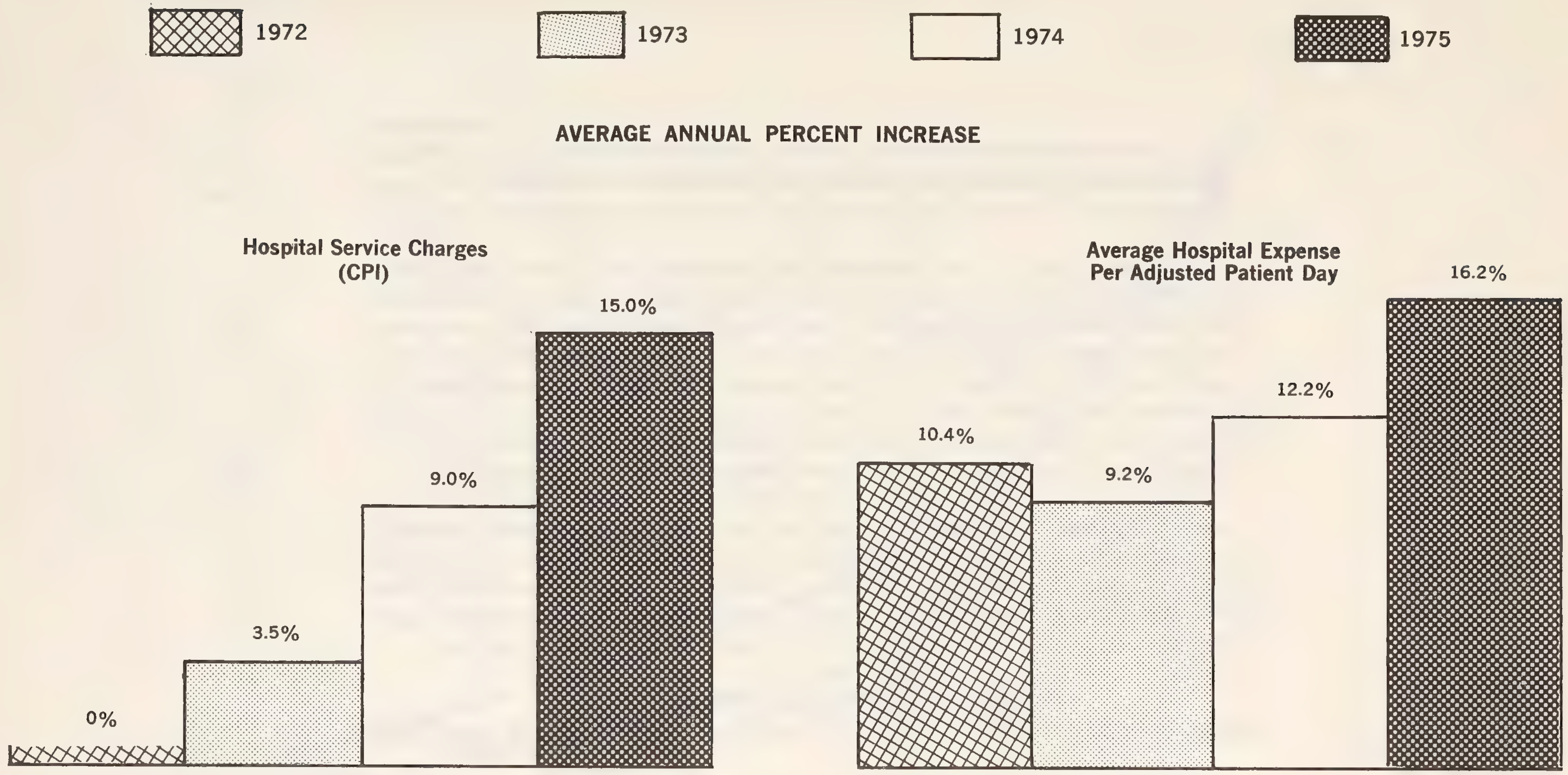
MD
DEL
N J
NEW YORK
VT
N H
MAINE
MASS
CONN
R I
D.C.
ALASKA
HAWAII

Source: *Hospital Statistics, 1974.* American Hospital Association, 1975.
*Statistical Abstract of the United States, 1975,* Bureau of the Census, U.S. Department of Commerce, July, 1975.

## CHART 2d.—*Hospital costs continue to increase substantially*

There are two ways to measure the daily cost of hospital care: the Bureau of Labor Statistics' average daily service charge and the American Hospital Association's average expense per patient day. Until recently, the average daily service charge, a component of the medical care index of the Consumer Price Index (CPI) included only the basic charge for room and board; all special services such as drugs, tests, and use of an operating room were excluded. Beginning with January 1972, the Bureau of Labor Statistics added seven auxiliary charges and developed a composite index for hospital service charges. The percentage changes for hospital daily charges from 1972 to 1975 indicated below are based on the composite index.



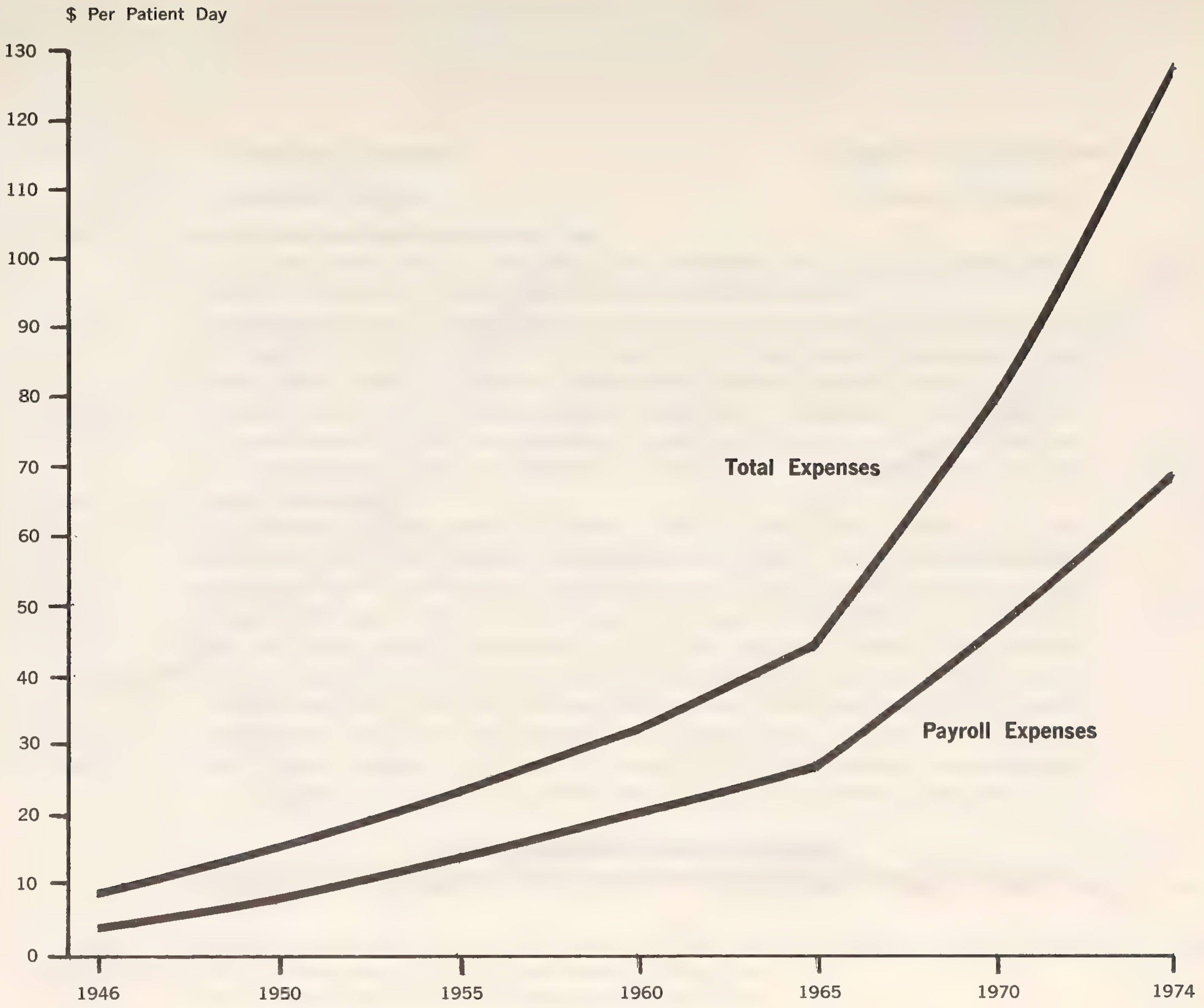
Source: Monthly Statistical Report: Summary of Selected Price, Cost, and Utilization Data for the Health Care Market in the United States, Office of Research and Statistics, Social Security Administration.

## CHART 2e.—*Payroll and other expenses of community hospitals have been rising at about the same rate*

Hospital expenses per patient day have increased over 1,264 percent since 1946, rising especially rapidly during the last several years. Payroll and nonwage expenses—the two major cost components—represented approximately 60 and 40 percent respectively of the total in 1974. These percentages have remained relatively constant over the last decade although there is a small, recent downward trend for the wage cost proportion.

Among the factors contributing to the rise in hospital expenses are technological changes, increased demand, and rising costs of labor and supplies. Most other industries increased their output by combining improvements in the organization of productive activity with the substitution of capital equipment for labor. In the hospital industry, however, organizational change has been slow. Improvements in medical technology have led to changes not only in the types of cases treated by hospitals but also in the methods of treatment which now require more expensive equipment as well as more highly skilled labor.

The public also demands more—a larger number of more costly services—from the hospital now than it did two decades ago because of rising income, increasing insurance coverage, and changing demographic characteristics of the population.



Source: *Medical Care Expenditures, Prices, and Costs: Background Book*, Office of Research and Statistics, Social Security Administration, Department of Health Education and Welfare, September 1975.

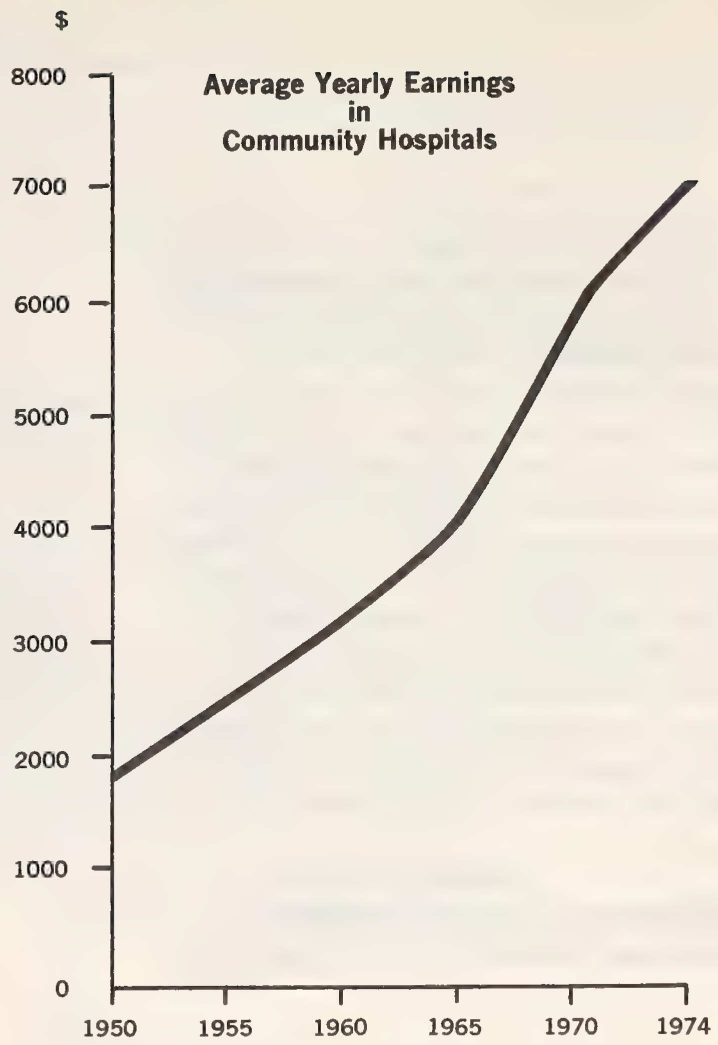
*Hospital Statistics, 1974*, American Hospital Association, 1975.

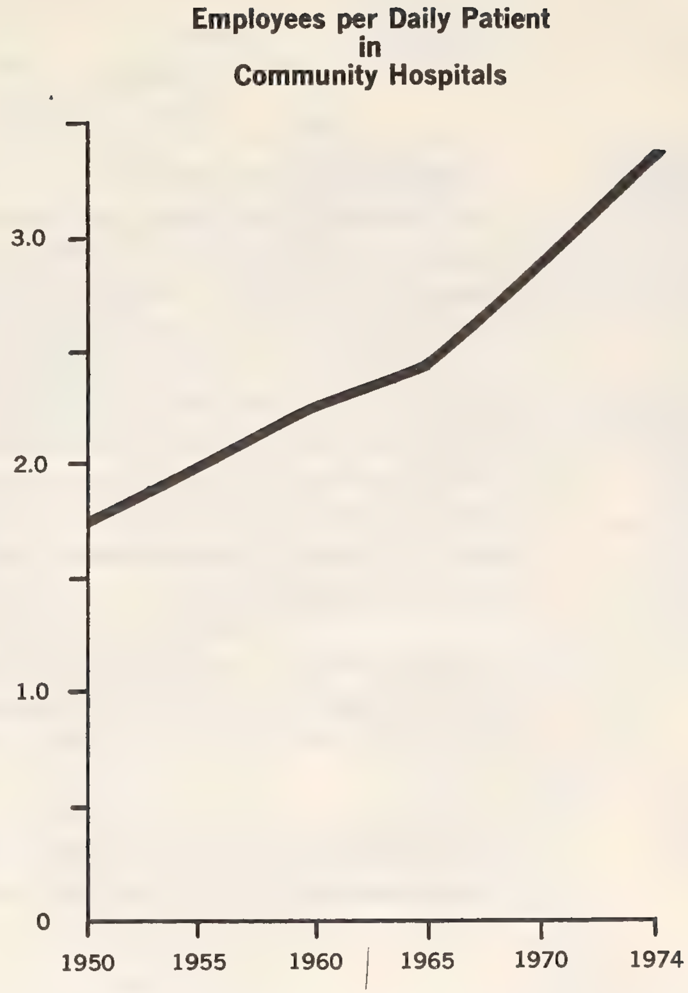
## CHART 2f.—*Both average earnings and employment per patient have increased substantially*

Increases in payroll costs have two basic elements—rising earnings levels and a larger number of employees. Average earnings of hospital workers have increased steadily over the last two decades as a result of several factors. Skill requirements have increased as medical treatment methods have become more sophisticated. Increasing demand for hospital services forced hospitals to compete for skilled labor in increasingly tight labor markets. Collective bargaining agreements, while still not pervasive, have been increasing in the hospital industry, adding to pressures for higher wages. Finally, the application of the minimum wage law to hospital employees has helped to close the gap between the earnings of traditionally low-paid hospital workers and workers in other service industries.

At the same time, the number of employees necessary to care for the average patient has increased markedly, from 1.8 in 1950 to 3.3 in 1974. Changes in treatment methods have tended to make use of additional equipment and skilled labor to run it, without eliminating the need for other kinds of labor. Hospitals have also been forced to hire more persons who are unskilled to fill in for skilled labor in short supply. Some of the numerical increase in employees, however, may reflect a shortening of the average work week.

Thus, wage costs of hospitals have increased as a result of using more employees paid at higher wage rates.





Source: *Medical Care Expenditures, Prices, and Costs: Background Book*, Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, September 1975.
*Hospital Statistics, 1974*. American Hospital Association, 1975.

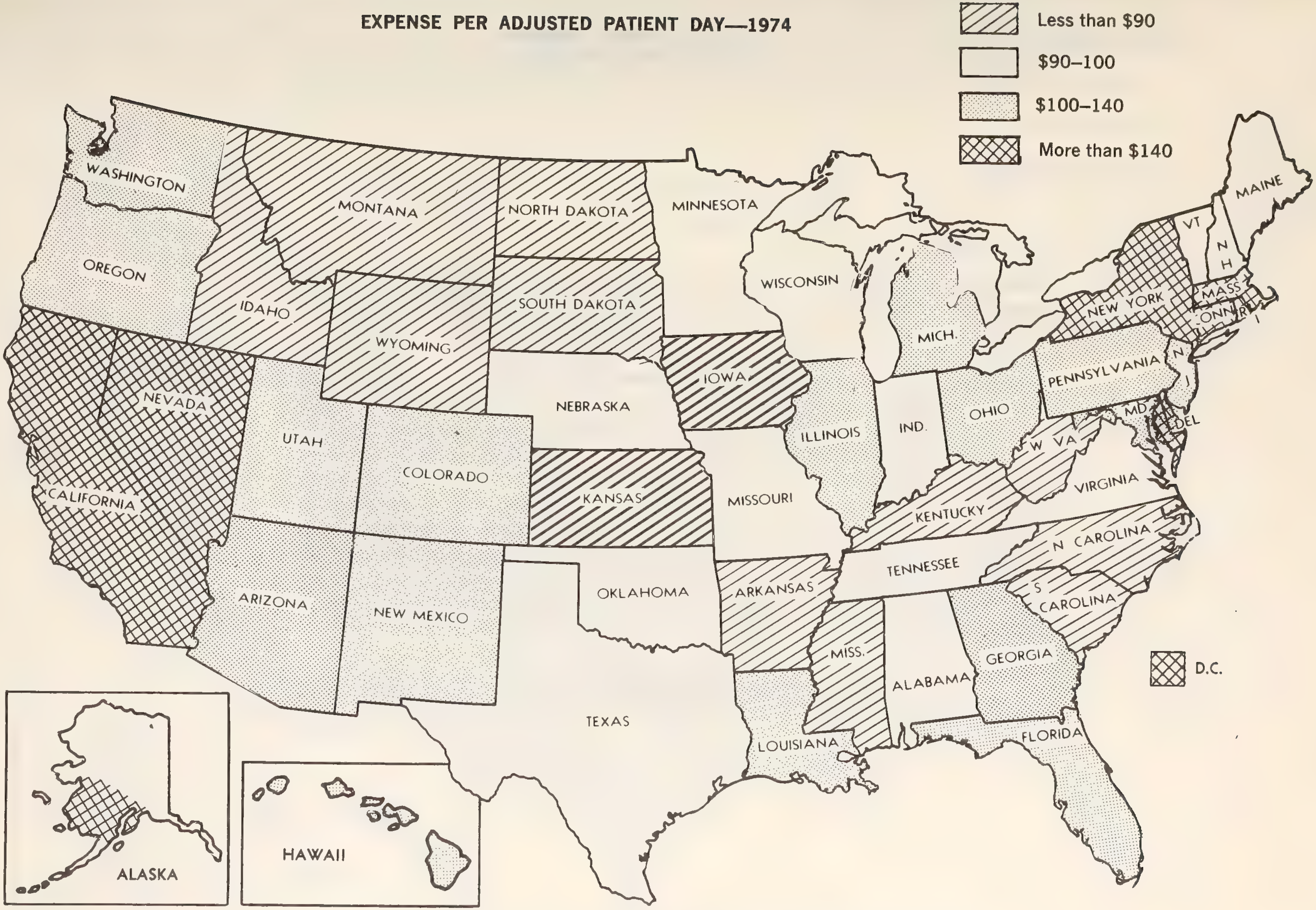
## CHART 2g.—*Expense per adjusted patient day in community hospitals varies considerably—from $78 in Mississippi to $163 in Alaska*

Nationally, total expense per adjusted patient day (includes inpatient days and an estimate of equivalent days for outpatient visits) in 1974 ranged from a low of $78 in Mississippi to a high of $163 in Alaska. The total expense per adjusted day for the entire United States was $113.55.

The cost level of hospital care is related to various factors. Costs tend to be higher where personal income is above average because hospitals must compete for labor in the local market. Patient day costs also tend to be higher where length of stay is relatively short. Many of the expensive diagnostic tests used in present-day medical care are administered in the first day or two or a hospital stay; after that daily costs decline. Thus the longer the average patient stays, the lower his average cost per day.

In addition, costs are higher where occupancy rates are low. If a hospital is used more intensively, then fixed costs can be distributed over more patients, thus reducing the average cost. Finally, costs may be higher where hospitals are larger. Bigger hospitals tend to provide more specialized services and facilities than smaller hospitals. They also tend to treat more difficult cases.

## EXPENSE PER ADJUSTED PATIENT DAY—1974


▨ Less than $90
☐ $90–100
░ $100–140
▩ More than $140
WASHINGTON
OREGON
CALIFORNIA
NEVADA
IDAHO
MONTANA
WYOMING
UTAH
ARIZONA
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
MINNESOTA
IOWA
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
ILLINOIS
MICH.
IND.
OHIO
KENTUCKY
TENNESSEE
MISS.
ALABAMA
GEORGIA
FLORIDA
S CAROLINA
N CAROLINA
VIRGINIA
W VA
MD
DEL
N J
PENNSYLVANIA
NEW YORK
VT
N H
MAINE
MASS
CONN
R I
▩ D.C.
ALASKA
HAWAII

Source: *Hospital Statistics, 1974*, American Hospital Association, 1975.

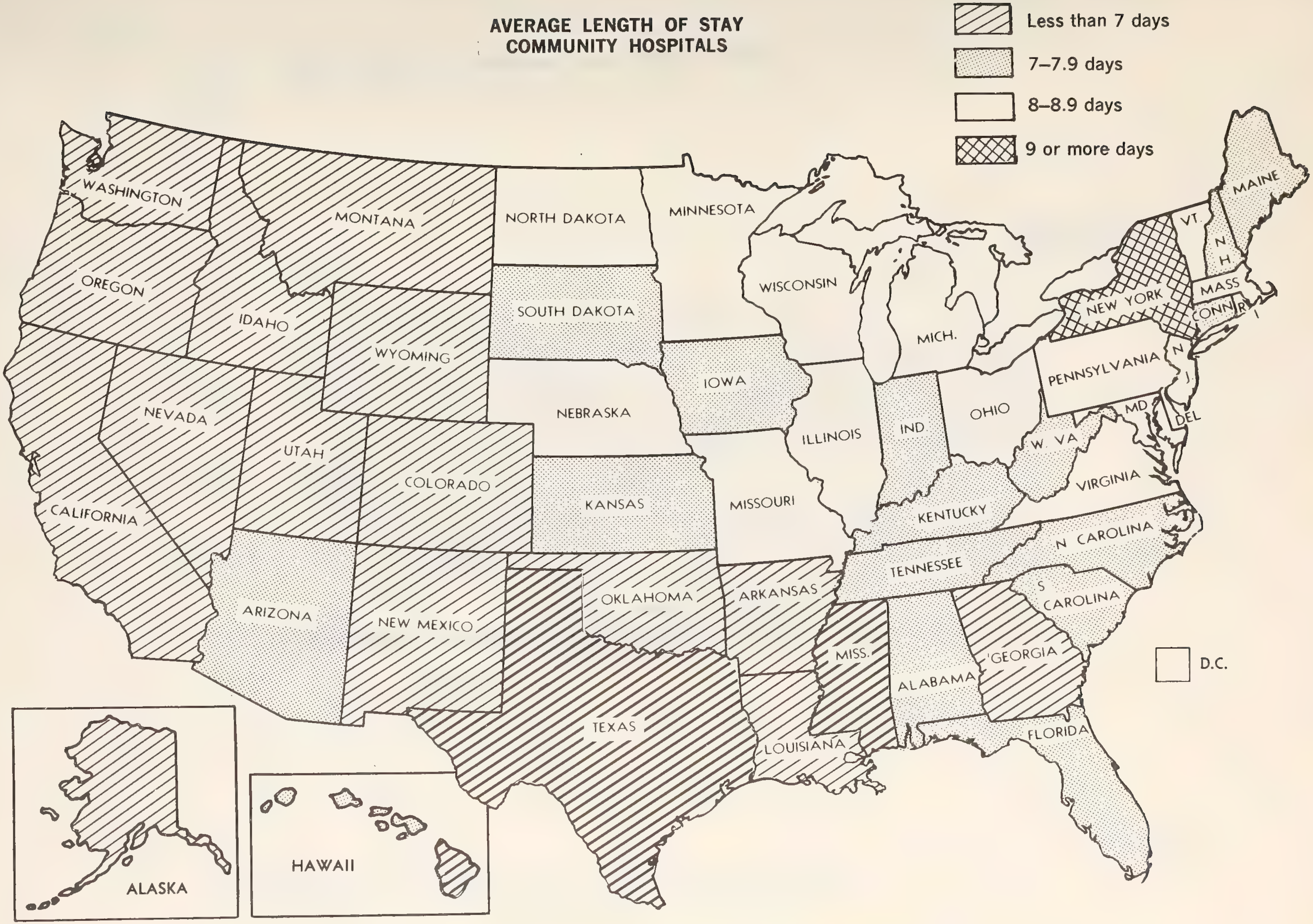
## CHART 2h.—*Average length of stay in hospitals varies substantially*

Like most other characteristics of the hospital industry, average length of stay varies by area, from a low 4.7 days in Alaska to 9.8 days in New York. Patterns of medical practice differ from State to State regarding admission and discharge policies and utilization review practices. The incidence of different kinds of disease differs from one area to another as does the age distribution of the population. In sparsely populated areas where people must travel far for medical care, minor cases may be hospitalized to avoid repeat visits by the physician. This factor results in shorter stays.

Economic characteristics such as income levels and insurance coverage also have important impacts. Hospitals with high occupancy rates may postpone elective admissions, yielding a case-mix composition with relatively longer stays.

Length of stay also differs according to the type of hospital. Patients in State and local hospitals averaged 7.7 days in 1974. Those in nonprofit and for-profit hospitals averaged 7.9 and 6.7 days, respectively, in the same year.

## AVERAGE LENGTH OF STAY COMMUNITY HOSPITALS


Less than 7 days
7–7.9 days
8–8.9 days
9 or more days
WASHINGTON
MONTANA
NORTH DAKOTA
MINNESOTA
MAINE
VT.
N H.
OREGON
IDAHO
SOUTH DAKOTA
WISCONSIN
MASS
NEW YORK
CONN
R I
WYOMING
MICH.
IOWA
PENNSYLVANIA
N J.
NEVADA
NEBRASKA
ILLINOIS
IND
OHIO
MD
DEL
W. VA
UTAH
COLORADO
KANSAS
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VIRGINIA
KENTUCKY
CALIFORNIA
N CAROLINA
TENNESSEE
ARIZONA
NEW MEXICO
OKLAHOMA
ARKANSAS
S CAROLINA
MISS.
ALABAMA
GEORGIA
D.C.
TEXAS
LOUISIANA
FLORIDA
HAWAII
ALASKA

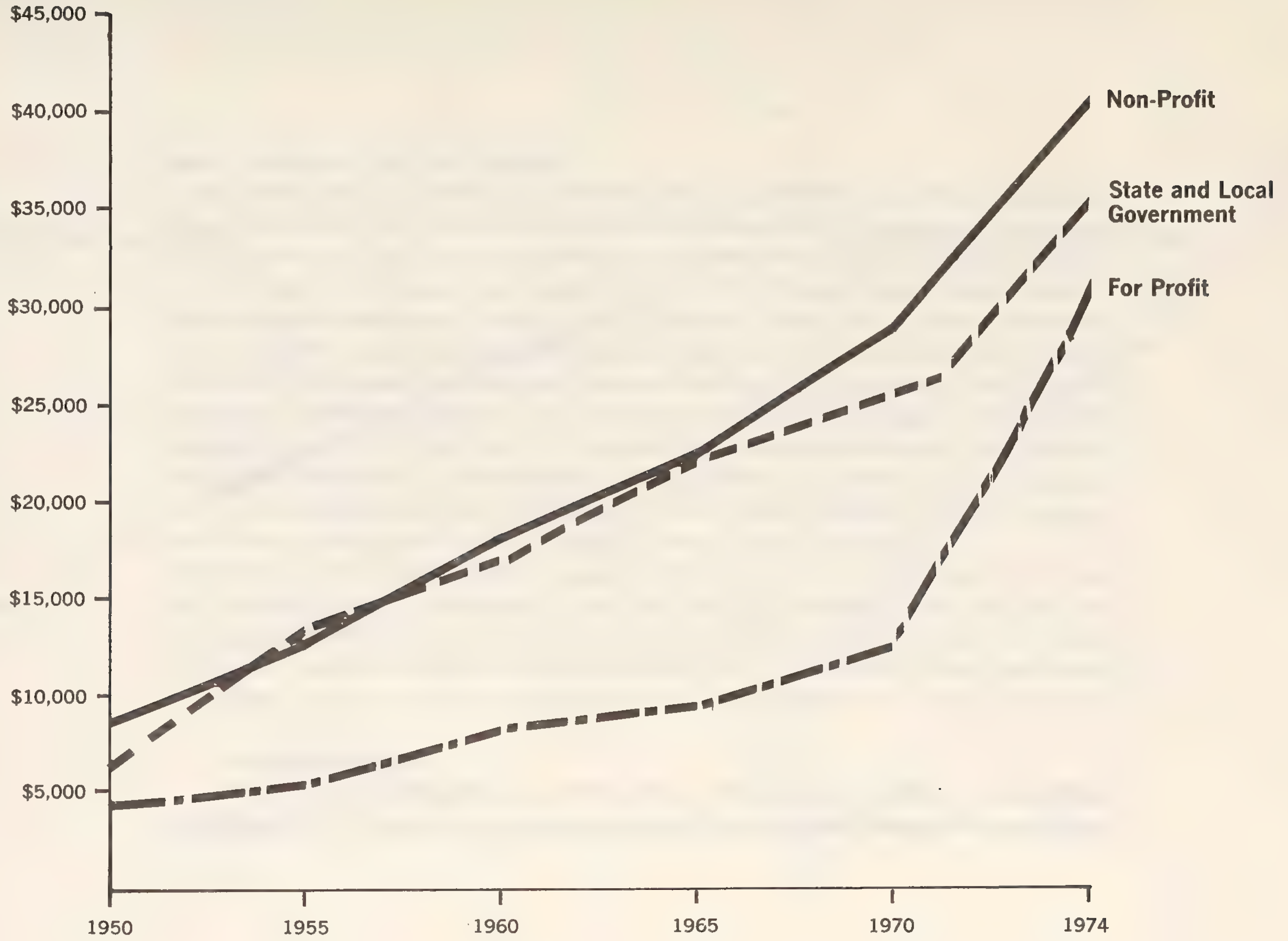
Source: *Hospital Statistics, 1974*, American Hospital Association, 1975.

### CHART 2i.—*Total investment in community hospitals amounted to $28 billion in 1974*

The investment in community hospital plant assets amounted to $28 billion in 1974, over nine times the amount reported in 1950. When converted to the amount per average daily patient load or the assets required per unit of average daily output, the rate of growth is slower—from $7,483 in 1950 to $39,891 in 1973, or five times the 1950 amount.

The value of assets in nonprofit hospitals only has grown from $8,265 per average daily patient load in 1950 to nearly $41,418 in 1974. The trend is similar for State and local government hospitals. For-profit hospitals, however, have shown much slower growth—from $4,337 per average daily patient load to $31,354 in the same period. For-profit hospitals have tended to be smaller and provide fewer specialized services than other hospitals.

## PLANT ASSETS PER AVERAGE DAILY PATIENT LOAD



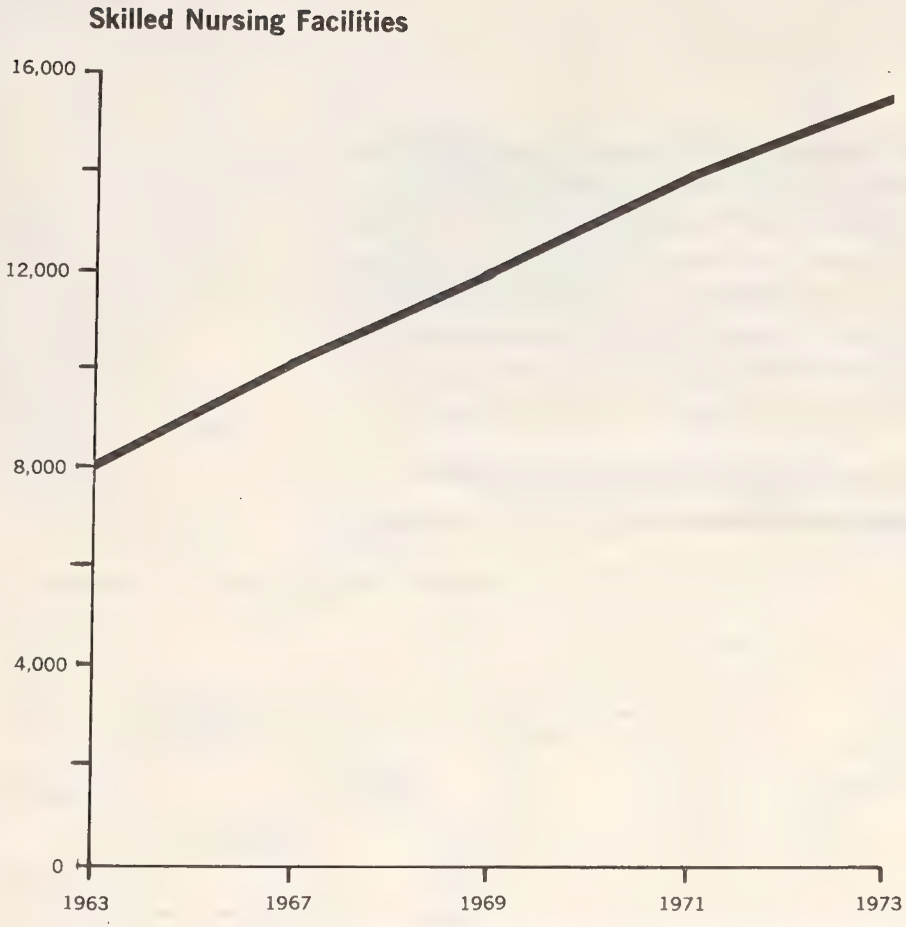
Source: *Medical Care Expenditures, Prices, and Costs: Background Book*, Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, September 1974.
*Hospital Statistics, 1974*. American Hospital Association, 1975.

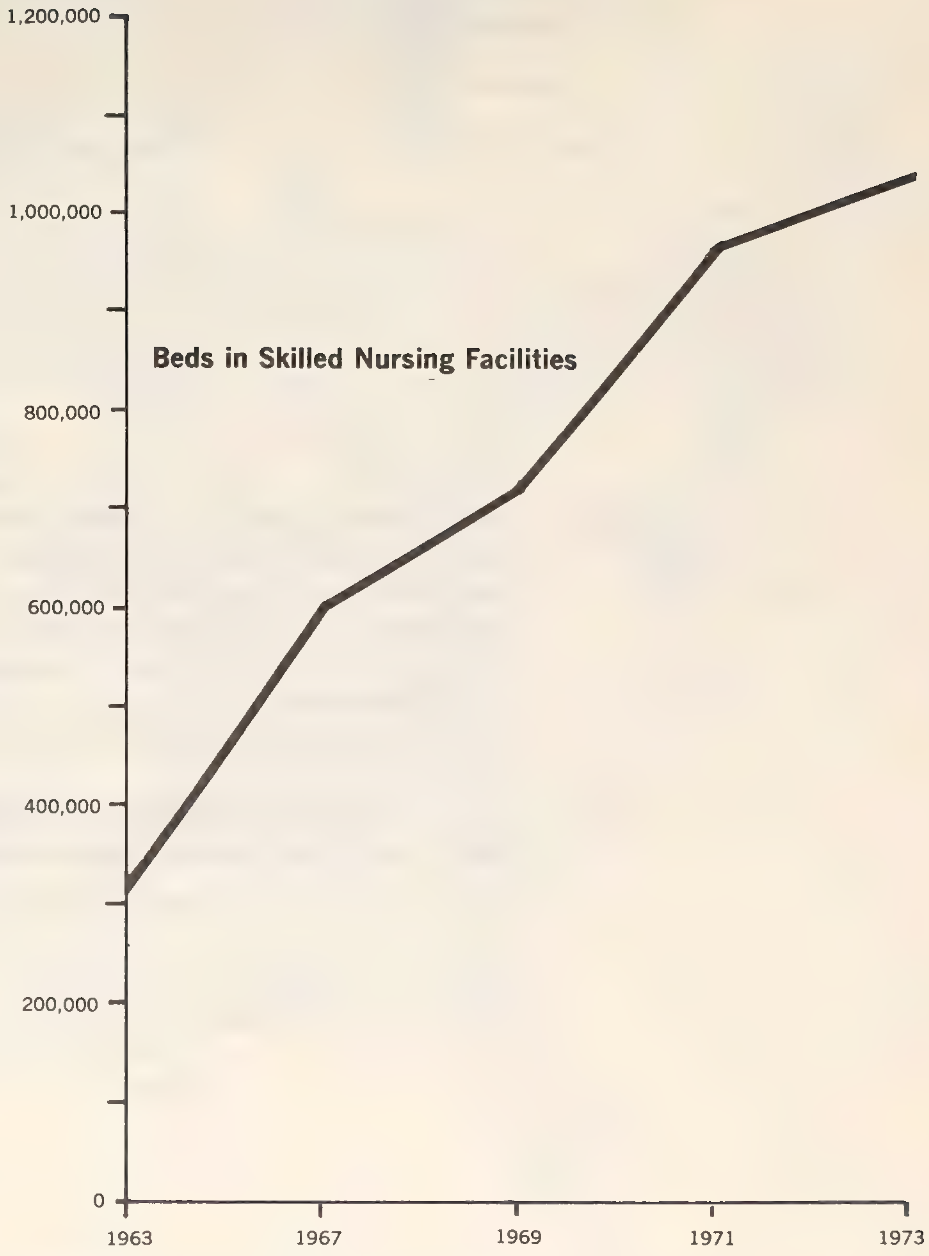
## CHART 2j.—*Since 1963 the number of skilled nursing facilities and the number of nursing home beds have increased substantially*

Since 1963 the Nation has registered substantial gains in the numbers of skilled nursing facilities and in the numbers of nursing home beds made available by these facilities. Skilled nursing homes include all those certified by medicare and/or medicaid as skilled nursing facilities, those certified by medicaid as intermediate care facilities, and all those providing some necessary care even though they are not certified under either program.

Several factors explain the growth in the number of skilled nursing facilities and beds: increases in the number of elderly persons, changes in the treatment patterns of illness as the result of advances in medical technology, and changes in family living arrangements, to name a few. In the middle 1960's the coverage under both medicare and medicaid of care provided in a skilled nursing facility and coverage under medicaid of care provided in an intermediate care facility also served to stimulate growth of this relatively new health care institution.

In 1963 there were 8,128 skilled nursing homes with 319,224 beds throughout the country. By 1973 the number of skilled nursing homes had grown to about 15,737 and the number of beds to approximately 1,175,865—an increase of 94 percent in the number of facilities and a 268 percent increase in the number of beds in a ten-year period.



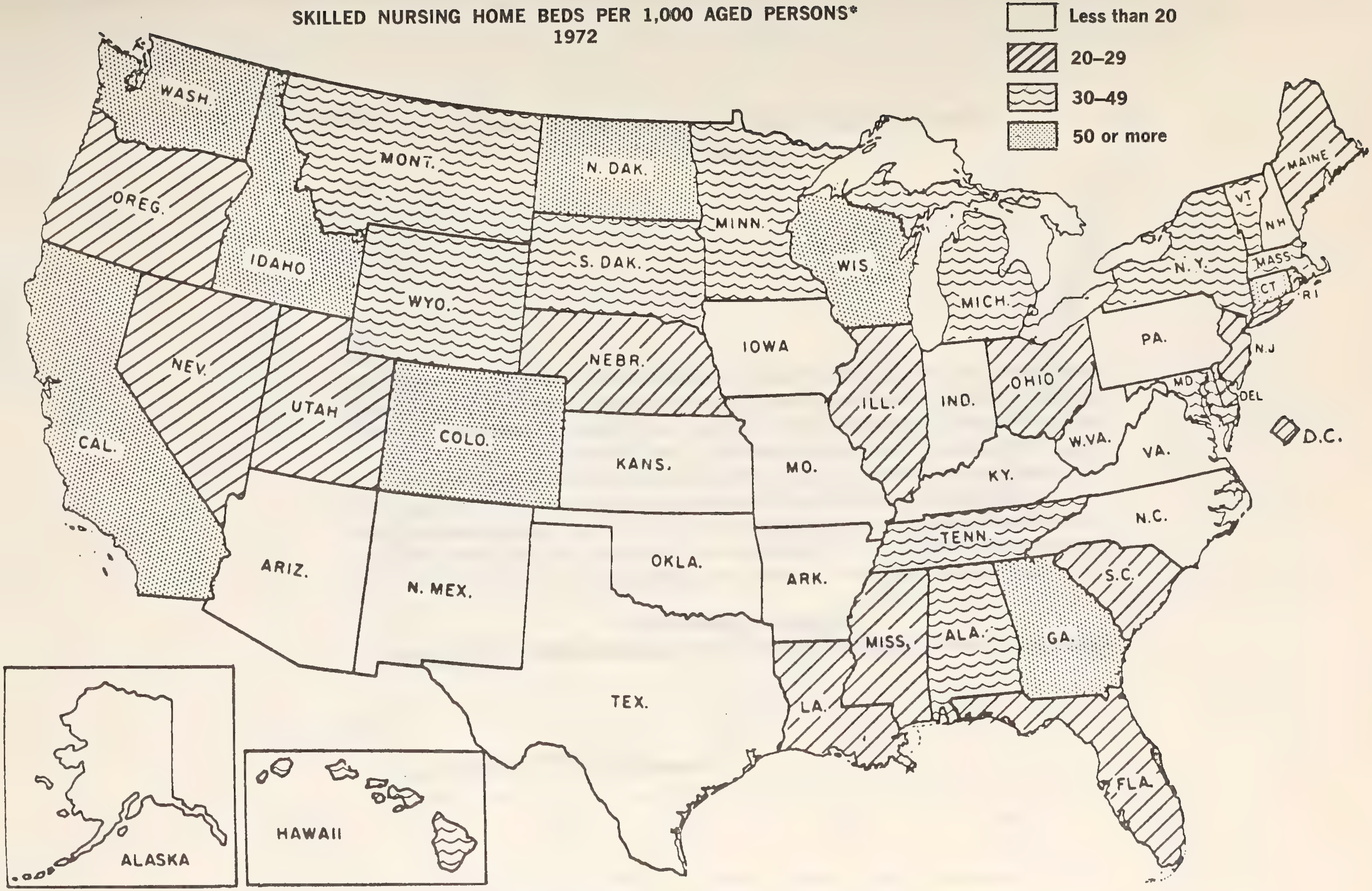


Source: *Medical Care Expenditures, Prices, and Costs: Background Book*, Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, September 1975.

## CHART 2k.—*The number of skilled nursing home beds per 1,000 aged persons varies markedly from State to State*

Although on a nationwide basis the number of skilled nursing home beds per 1,000 aged persons has increased by more than 2½ times since 1963, the numbers of such beds available in each State vary markedly. A State-by-State comparison of those nursing homes which are represented by the American Nursing Home Association and which in 1972 provided nearly 610,000 beds reveals that 16 States have fewer than 20 beds for every 1,000 of their residents 65 and older. Eight States, on the other hand, have 50 or more nursing home beds available for every 1,000 elderly persons.

SKILLED NURSING HOME BEDS PER 1,000 AGED PERSONS*
1972


☐ Less than 20
▨ 20–29
≋ 30–49
░ 50 or more
WASH.
OREG.
CAL.
IDAHO
NEV.
MONT.
WYO.
UTAH
ARIZ.
COLO.
N. MEX.
N. DAK.
S. DAK.
NEBR.
KANS.
OKLA.
TEX.
MINN.
IOWA
MO.
ARK.
LA.
WIS.
ILL.
MISS.
MICH.
IND.
KY.
TENN.
ALA.
OHIO
W.VA.
VA.
N.C.
S.C.
GA.
FLA.
PA.
N.Y.
VT
NH
MAINE
MASS
CT
RI
N.J
MD
DEL
D.C.
ALASKA
HAWAII

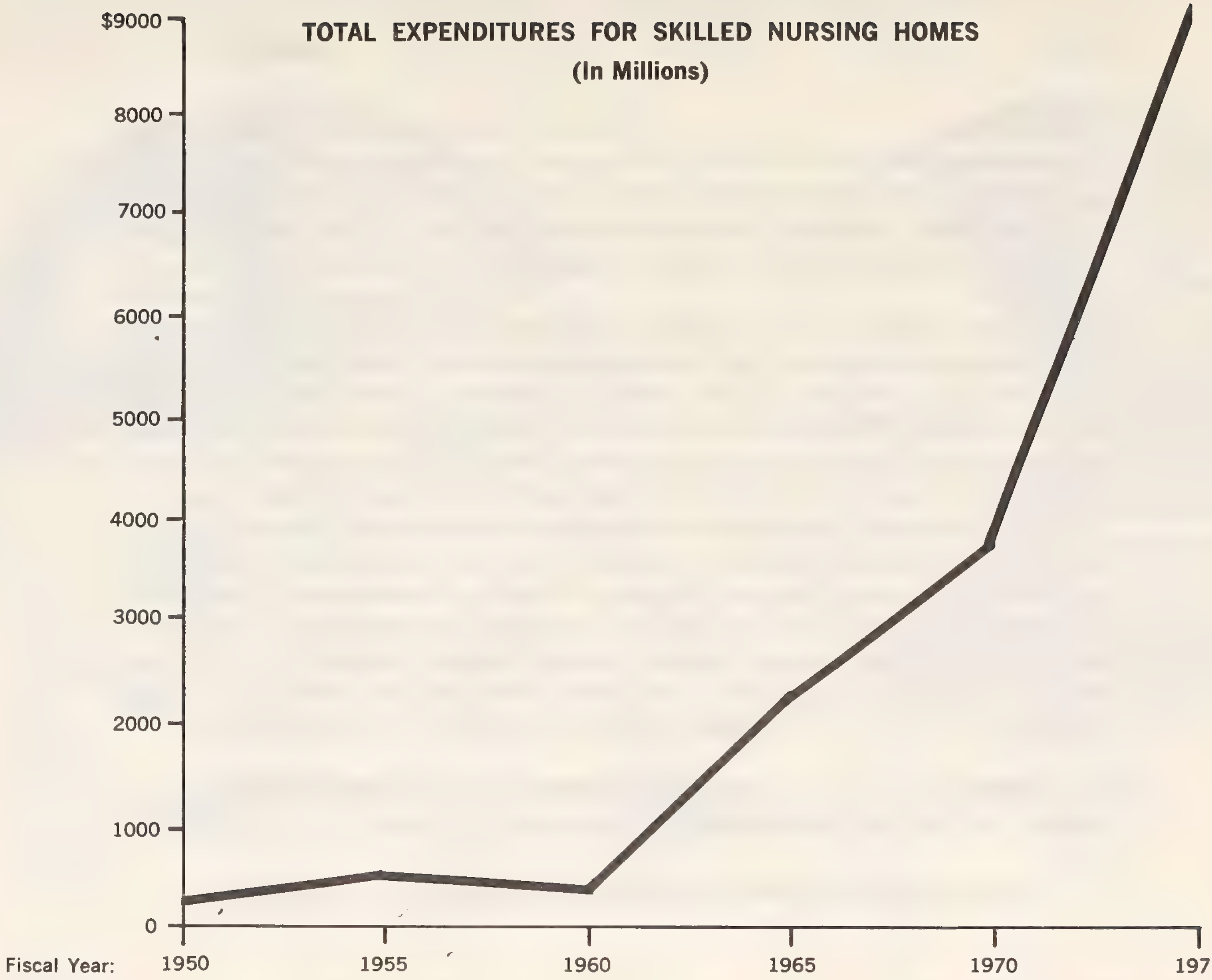
* Includes only those nursing homes represented by the American Nursing Home Association.

Source: "ANHA Facts in Brief". American Nursing Home Association. Publication No. 0873–1.
"Population Estimates and Projections". Bureau of the Census, U.S. Department of Commerce, Series p–25, No. 500, May 1973.

## CHART 21.—*Expenditures for skilled nursing home care have increased rapidly*

Accompanying the rapid growth in numbers of skilled nursing homes and nursing home beds in the country is a dramatic increase in expenditures for care in these facilities. In fiscal year 1950 expenditures for skilled nursing home care stood at $178 million. By 1975 expenditures had increased to $9 billion.

In the 1950's expenditures for services in skilled nursing homes increased, on the average, 10 percent per year. In the early 1960's when the Medical Assistance for the Aged program (Kerr-Mills) was implemented, expenditures rose significantly, with the increase averaging about 20 percent per year. With the enactment of medicare and medicaid in 1965, expenditures continued their rapid rise.



**TOTAL EXPENDITURES FOR SKILLED NURSING HOMES**

**(In Millions)**

Source: Mueller, Marjorie Smith and Robert M. Gibson. "National Health Expenditures, Fiscal Year 1975." *Social Security Bulletin*, February 1976, U.S. Department of Health, Education, and Welfare.

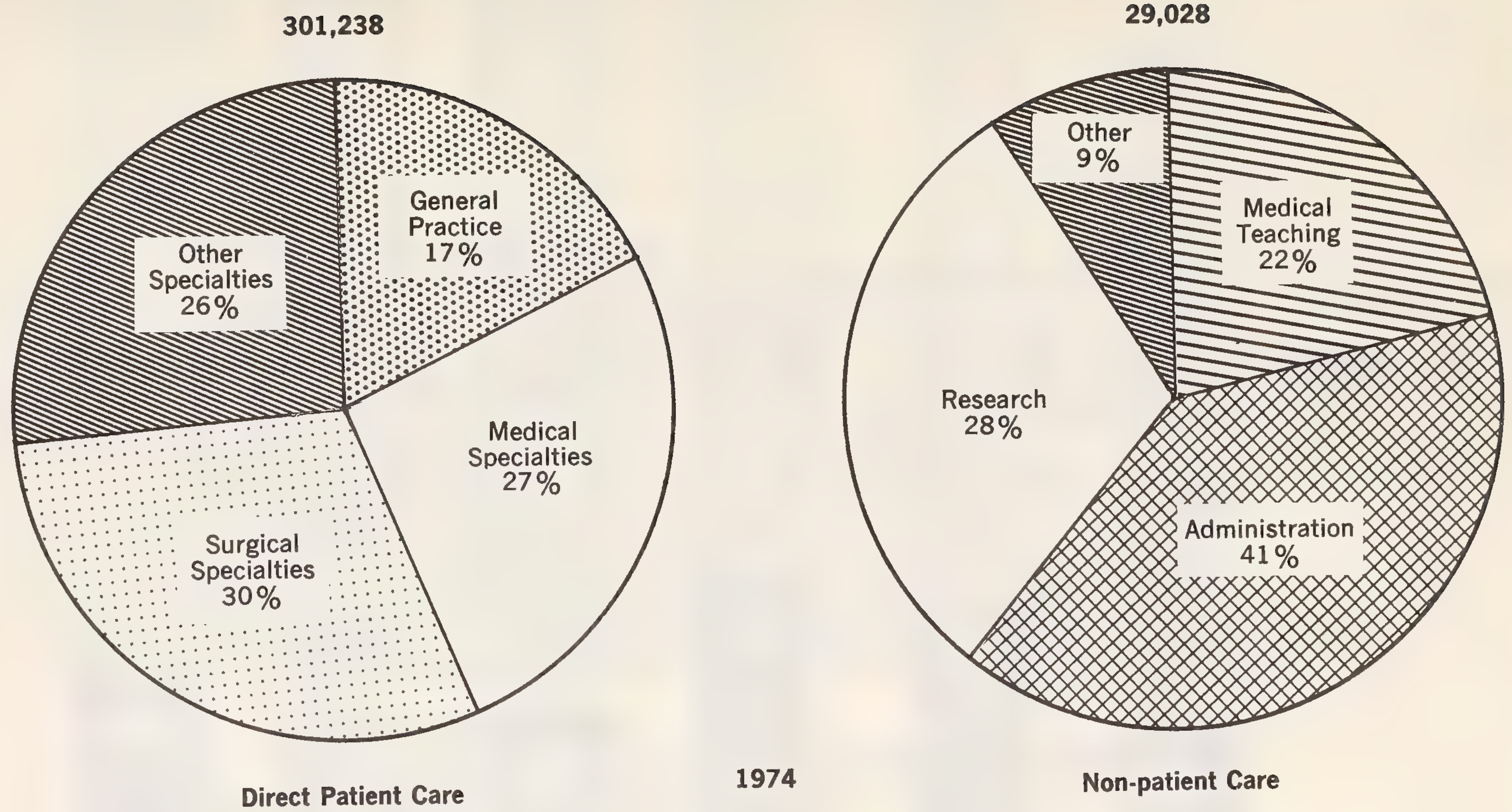
# Chapter 3. Information on Health Manpower

## CHART 3a.—*About 330,266 active physicians, or 156 per 100,000 population, provide medical services for the Nation*

Physicians are the indispensable central providers of medical care. Most are involved in patient care, although many are engaged in public health, medical education and research and hospital and medical care administration. The large majority of physicians are in private practice although some physicians are employed by governmental agencies, hospitals, medical schools, and insurance companies. Among those in private practice, most physicians either are in solo practice or have some arrangement to share expenses with other physicians.

Physicians employed by governmental agencies and other organizations work for a salary, though a large proportion of hospital-based physicians have other contractual arrangements. Self-employed physicians are usually paid on a fee-for-service basis. Physicians in prepaid group practices are often paid a salary (in some cases with a supplementary profit-sharing arrangement) for care of patients who pay a capitation premium—a flat periodic amount per enrollee.

In 1974, there were about 330,266 professionally active physicians (M.D.'s) in the United States, or 156 per 100,000 population. In addition, there were more than 12,000 active osteopaths (D.O.'s). Both kinds of physicians diagnose diseases, treat people who are ill, and in most States, use surgery, drugs, and all other accepted methods of medical care.



Direct Patient Care

1974

Non-patient Care

Source: Roback, G. A., *Physician Distribution and Medical Licensure in the U.S., 1974*, Center for Health Services Research and Development, American Medical Association, 1975.

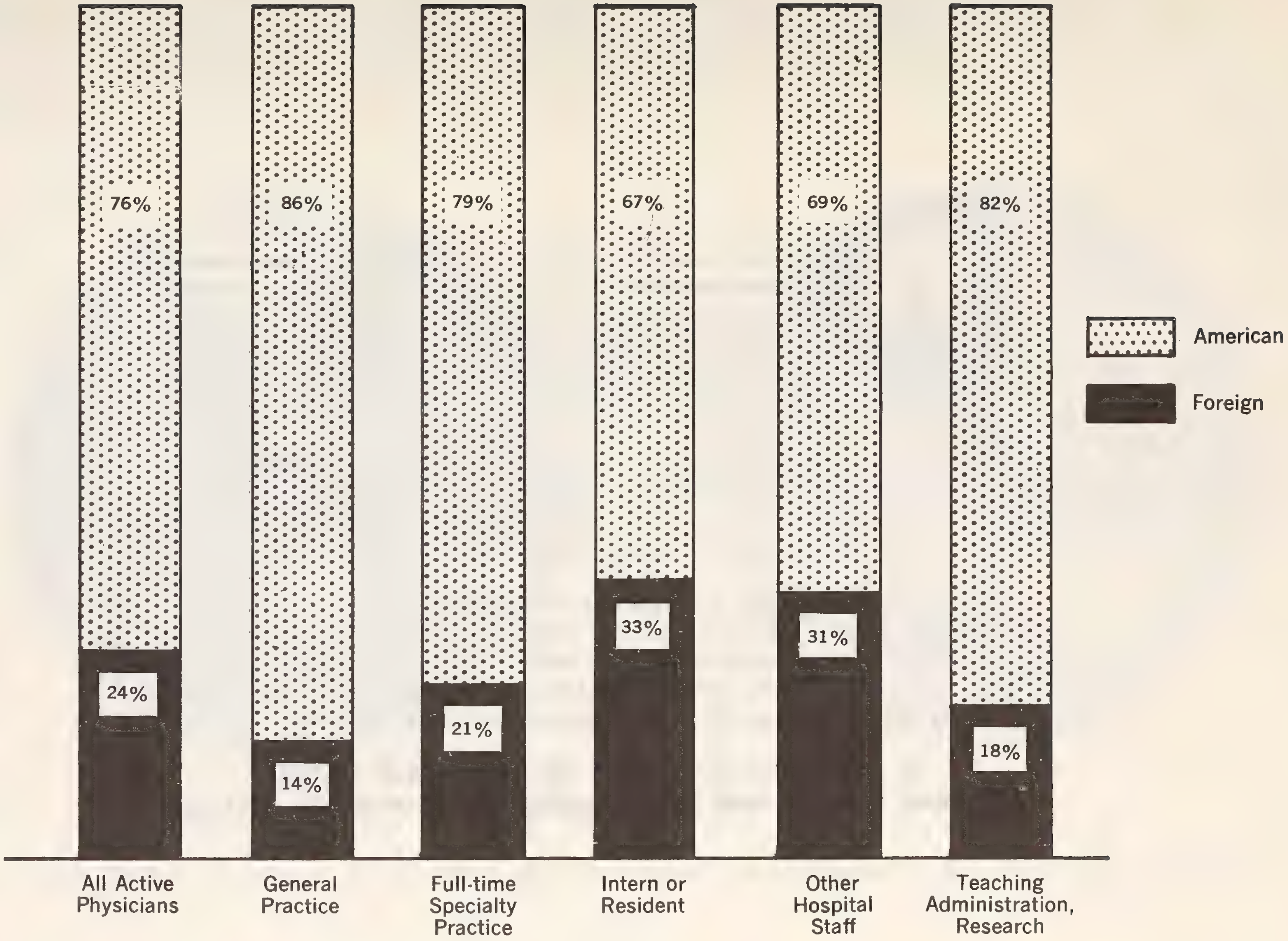
## CHART 3b.—*One out of every five active physicians is a graduate of a foreign medical school; for interns the proportion is considerably higher*

In 1973, there were 71,335 foreign medical graduates in the United States, comprising 20 percent of the active physician population. Since 1950 there has been a rapid and dramatic increase in the number of foreign medical graduates coming to the United States, particularly over the last few years.

The smallest representation of the foreign medical graduates (14 percent) is found in general practice. Their largest representation is among interns and residents (33 percent) and other hospital staff (31 percent).

In 1973, only 54.7 percent of the foreign medical graduates passed State board examinations, compared with 86.7 percent of U.S. medical graduates. Those who do not pass frequently remain in the United States, working in jobs for which requirements for licensure are waived.

Foreign medical graduates who enter private practice tend to settle in suburban areas and in the Northeast.



CALENDAR YEAR 1973

Source: Vahovich, Steve G., *Profile of Medical Practice*, Center for Health Services Research and Development, American Medical Association, 1974.

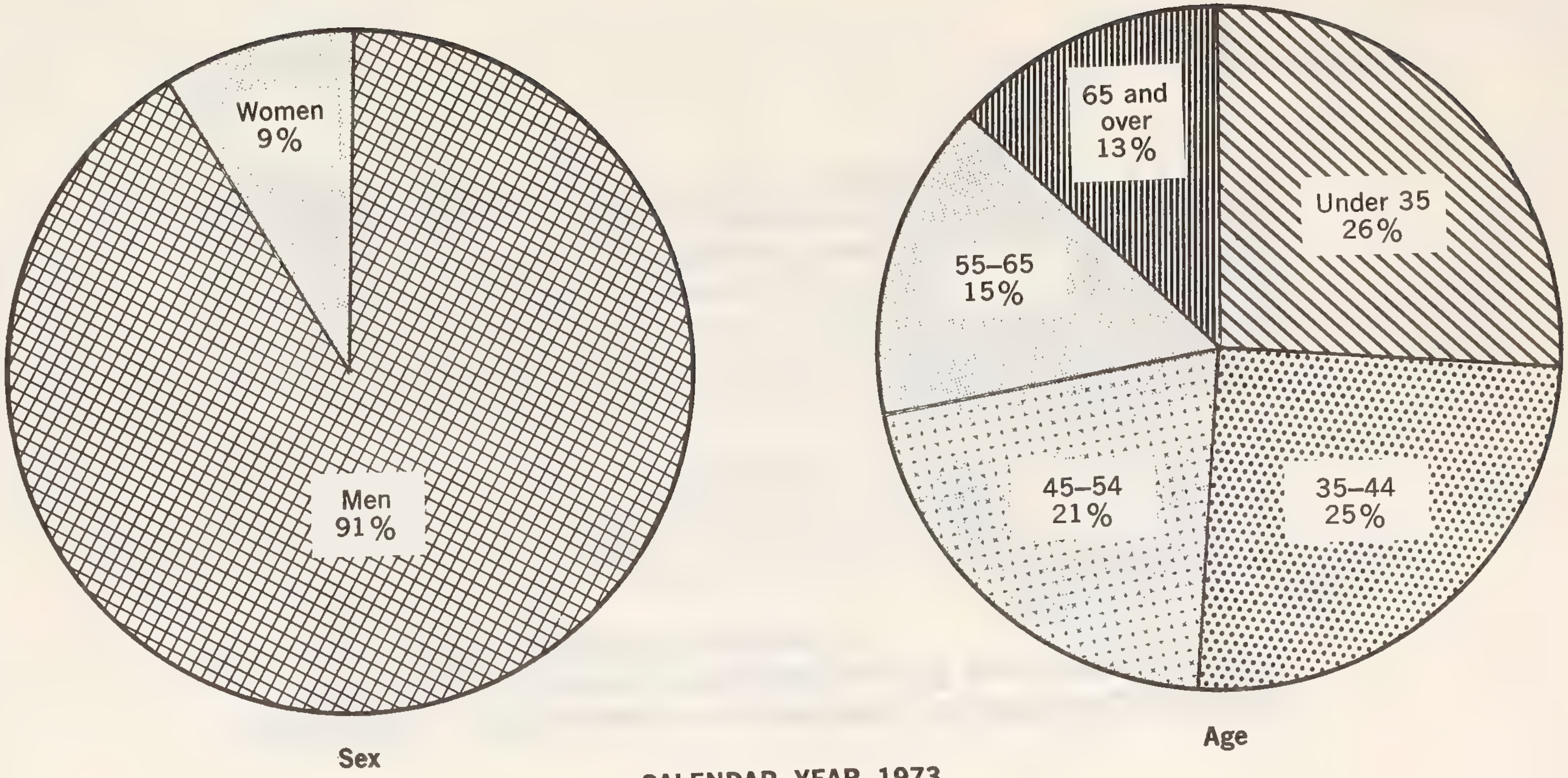
## CHART 3c.—*Nearly all physicians—91 percent—are men; the largest proportion—26 percent—is under age 35*

Nearly all active physicians are men; only 9 percent are women. In many other industrial nations women represent a much higher proportion of the physician supply. In the United States, however, medical schools, until recently, have been reluctant to admit women. The proportion would be even lower if it were not for the fact that a higher proportion of foreign medical graduates are women.

The largest proportion of physicians (26 percent) is in the under-35 age group. One-fourth are in the 35–44 age group.

The smallest group of physicians (13 percent) are aged 65 and over. General practitioners have a higher average age than all physicians in medical specialties.

Direct statistics on racial characteristics of physicians are not available. But studies indicate that in the 1974–75 school year, only 6.3 percent of the U.S. medical school enrollment was black. In the 1970–71 school year, the proportion was only 3.8 percent. For other minority groups, the proportion enrolled is less—1.2 percent are Mexican-Americans and .3 percent are Puerto Ricans. However, these proportions have been rising in recent years.



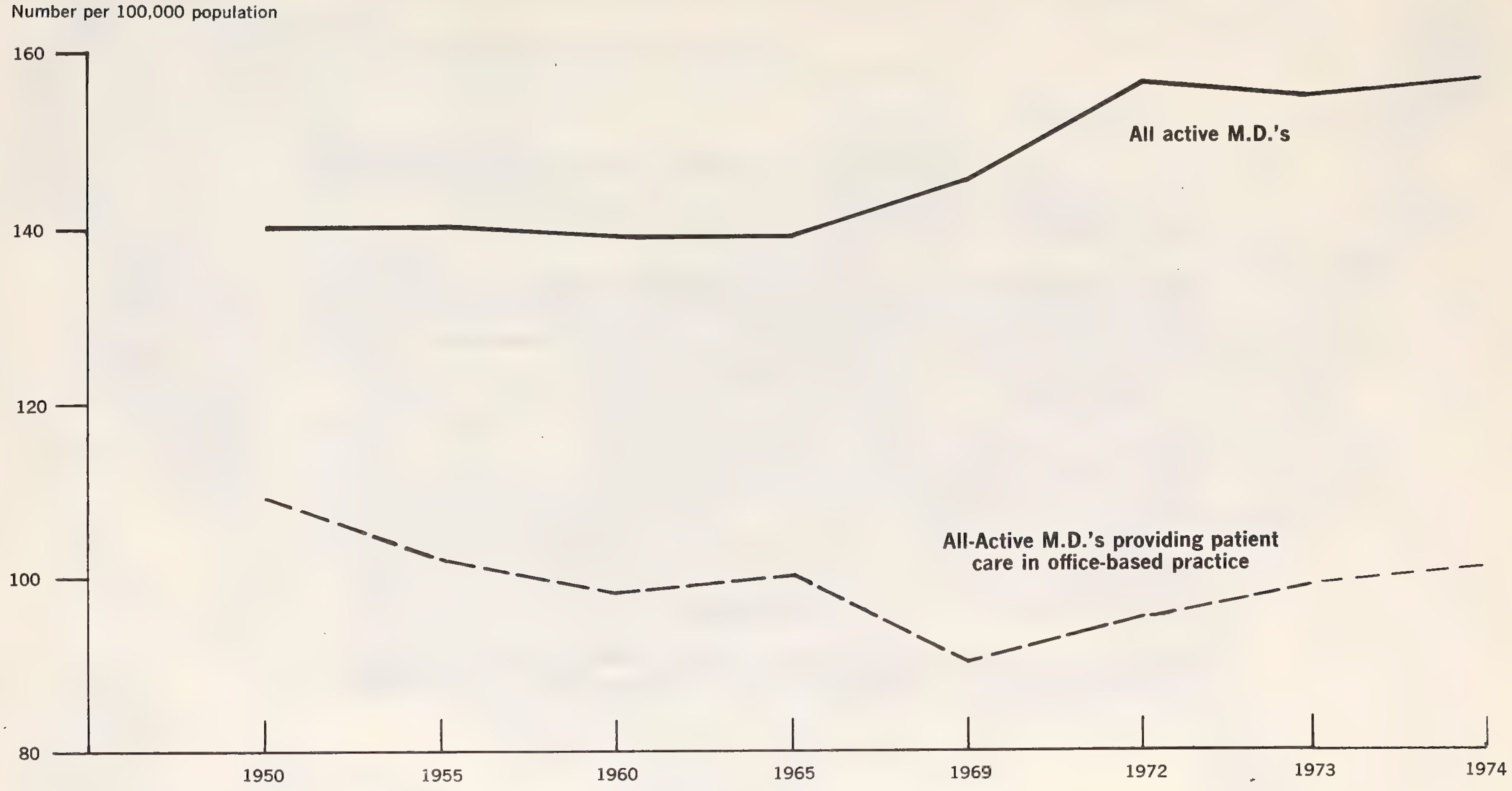
CALENDAR YEAR 1973

Source: *Profile of Medical Practice*, Center for Health Services Research and Development, American Medical Association, 1974.

## CHART 3d.—*The number of physicians per 100,000 population has risen, but those providing patient care have not kept pace with population increases*

Since 1950, the total number of professionally active physicians has increased by more than 138,000, or approximately 72 percent. In terms of M.D.'s per 100,000 persons, the rate has risen from 140 in 1950 to 156 in 1974, indicating that total output of M.D.'s has more than kept pace with population growth.

Numbers of M.D.'s actually treating patients in office-based practice, however, have not followed the same pattern of growth. The proportion of all active physicians providing patient care in office-based practice decreased for many years, but since 1969 has been rising slightly to 97 per 100,000 population in 1974. This indicates that more and more M.D.'s are opting for a hospital-based practice or for areas of professional activity other than patient care, such as medical research, teaching, or administration.



Source: Roback, G. A., *Physician Distribution and Medical Licensure in the U.S., 1974*, Center for Health Services Research and Development, American Medical Association, 1975.

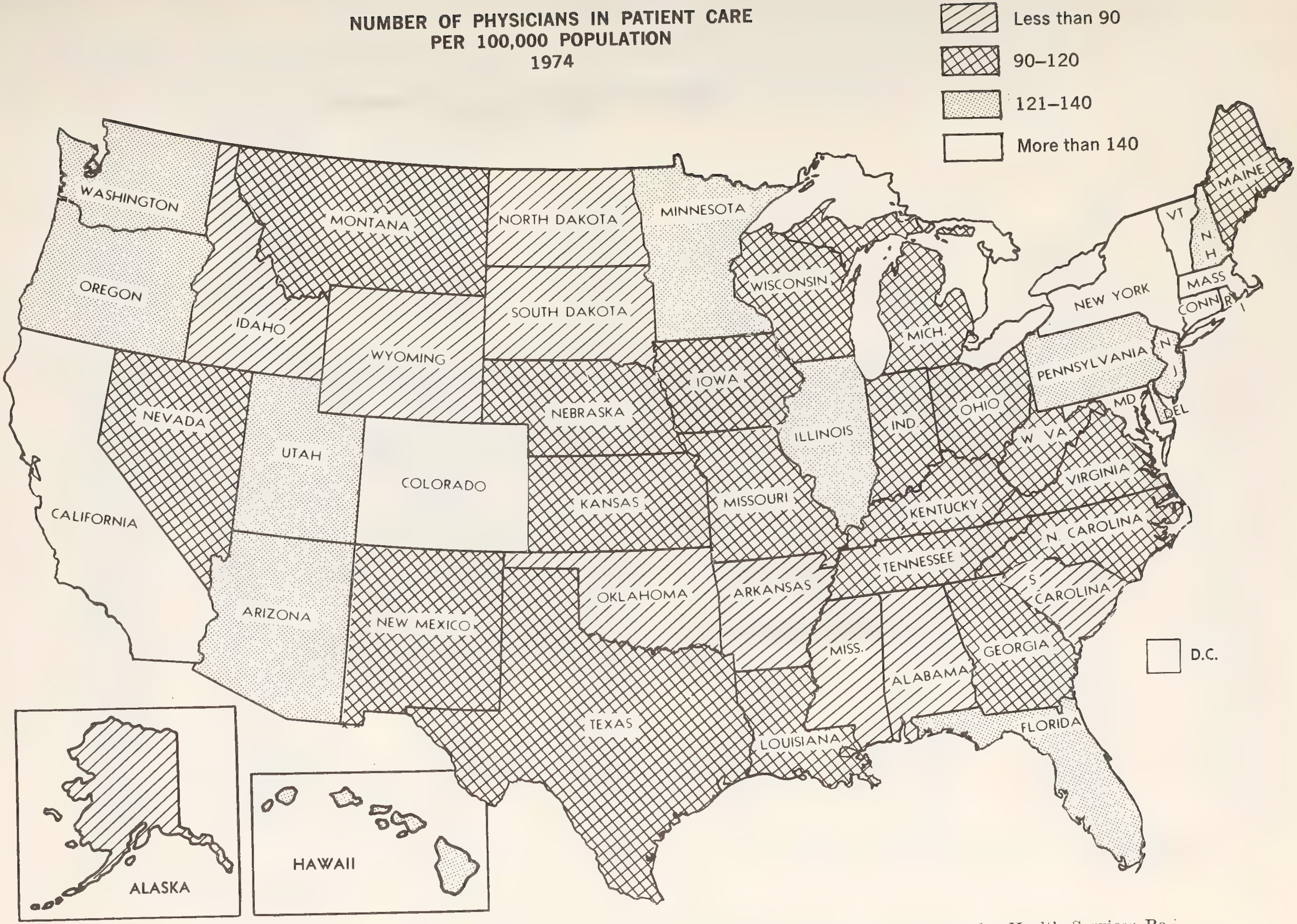
## CHART 3e.—*The number of physicians per 100,000 persons varies from 73 in South Dakota and Alaska to 198 in New York*

The number of civilian non-Federal physicians per population unit providing patient care varies enormously throughout the country. For every 100,000 persons in South Dakota and Alaska, there are only 73 physicians providing such care. In other words, each physician there serves about 1,370 people. In New York, the rate per 100,000 is 198 or only 505 persons per physician. The District of Columbia, which serves parts of Virginia and Maryland, has 333 physicians per 100,000 District of Columbia residents.

Besides South Dakota, there are eight other States with less than 90 physicians per 100,000 population. Five of these are in the South. Over two-fifths of the States—22—have 90–120 physicians per 100,000; 12 States have a rate of 121–140; and in 8 States and the District of Columbia there are over 140 physicians per 100,000 persons. Most of the States in this last group are in the Northeast.

Even within States with high physician-population ratios, many areas suffer from a physician shortage. People in low income and rural areas may find the number of physicians much lower than the State average.

NUMBER OF PHYSICIANS IN PATIENT CARE
PER 100,000 POPULATION
1974


▨ Less than 90
▦ 90–120
░ 121–140
☐ More than 140
WASHINGTON
OREGON
CALIFORNIA
IDAHO
NEVADA
MONTANA
WYOMING
UTAH
ARIZONA
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
MINNESOTA
IOWA
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
ILLINOIS
MICH.
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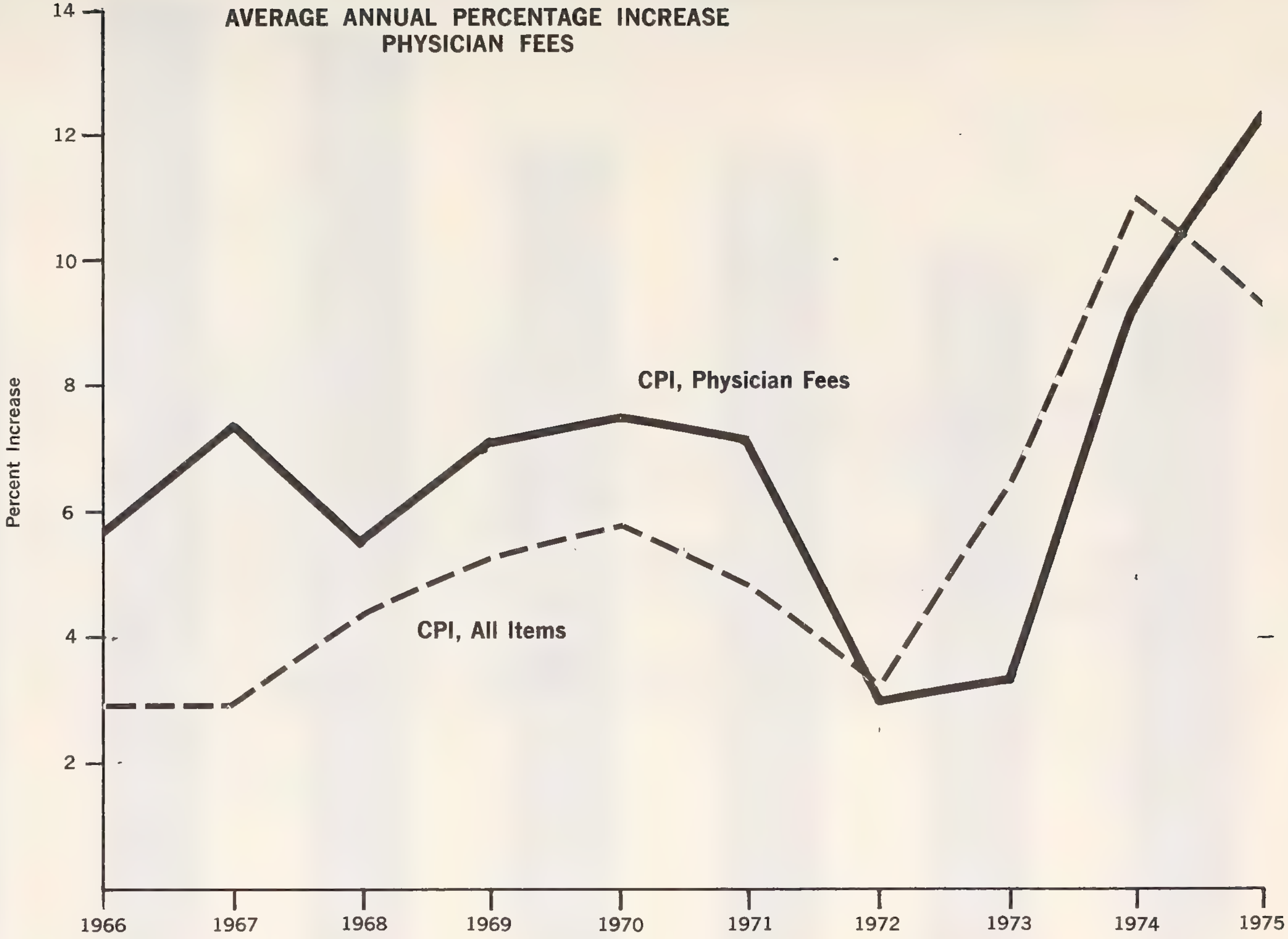
OHIO
KENTUCKY
TENNESSEE
MISS.
ALABAMA
GEORGIA
FLORIDA
S CAROLINA
N. CAROLINA
VIRGINIA
W VA
PENNSYLVANIA
NEW YORK
MD
DEL
N J
CONN
R I
MASS
VT
N H
MAINE
D.C.
ALASKA
HAWAII

Source: Roback, G. A., *Physician Distribution and Medical Licensure in the U.S., 1974*, Center for Health Services Research and Development, American Medical Association, 1975.

## CHART 3f.—*Physicians' fees accelerated beginning in 1966*

During 1950–65, physician fee increases averaged 3.2 percent annually, compared with 1.8 percent for all items. An acceleration in physicians' fees occurred in 1966, perhaps partly in anticipation of the medicare program. Many observers believe that the lowering of financial barriers to physicians' services through wider insurance coverage, including medicare and medicaid, has stimulated greater demand.

During the Economic Stabilization Program, August 1971 through April 1974, the rate of increase in physicians' fees declined, but it rose sharply in 1975 to a record 12.3 percent once the controls were lifted. Mandatory controls were in effect for the health industry throughout the ESP period, but were not continuously in effect for the rest of the economy.

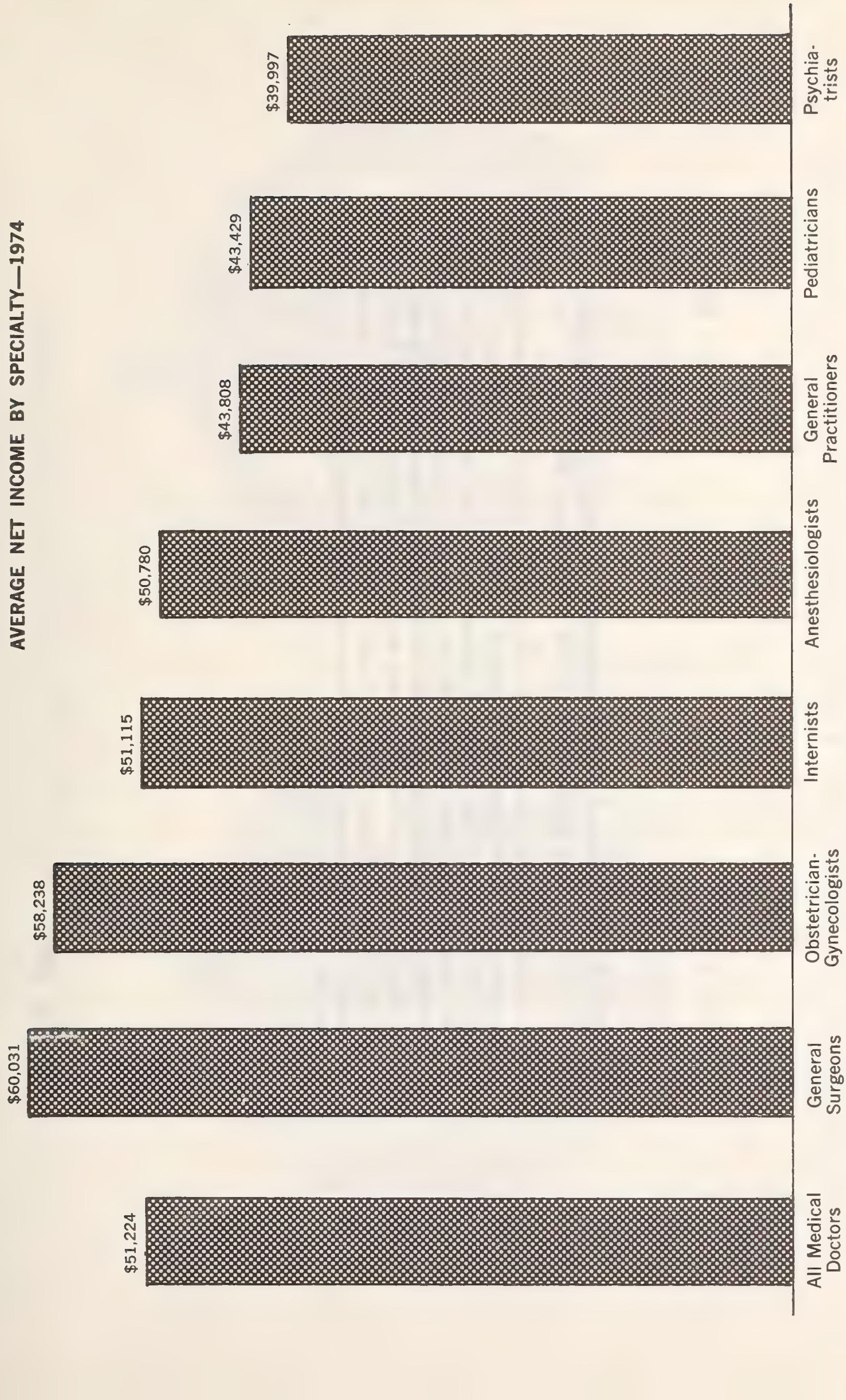


Source: Summary of Selected Price, Cost, and Utilization Data for the Health Care Market in the United States, Office of Research and Statistics, Social Security Administration, Department of Health, Education, and Welfare, December 1975–January 1976.

## CHART 3g.—*Physicians' incomes vary by specialty*

In 1974, estimated mean net income—the income after business expenses are deducted—amounted to $51,224 for physicians in private practice. When viewed by specialty, net income averaged highest for surgeons, $60,031, and lowest for psychiatrists, $39,997.

The 1974 ranking by specialty is basically the same as in 1968, with psychiatry moving from fifth to seventh place. The greatest increases in net income in the 5-year period are for the specialties with the highest incomes, with anesthesiology registering the largest gain—44 percent—and psychiatry registering the lowest—20 percent.



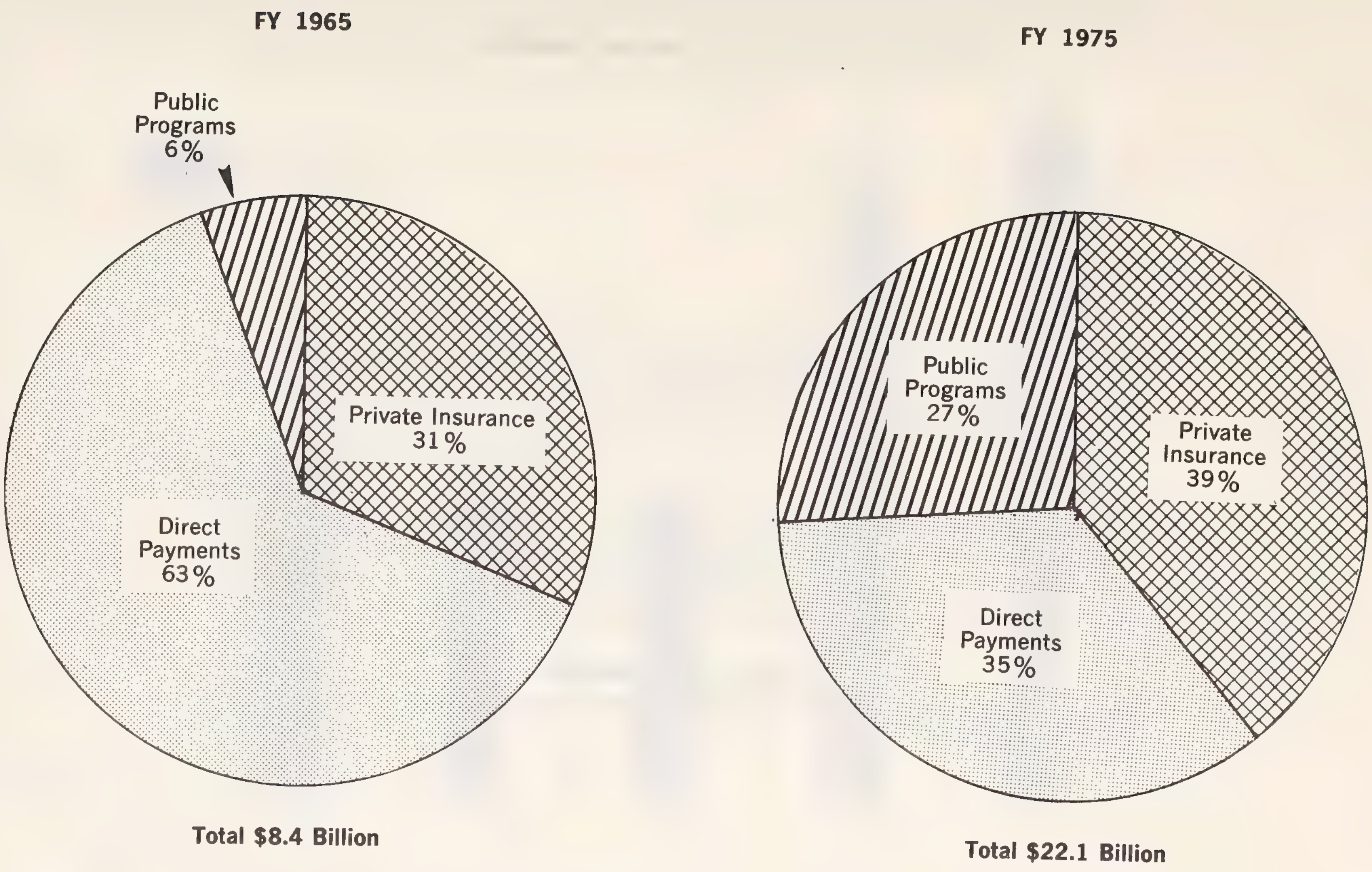
AVERAGE NET INCOME BY SPECIALTY—1974

Source: Center for Health Services Research and Development, American Medical Association, 1974.

## CHART 3h.—*Out-of-pocket expenditures account for a decreasing proportion of the physicians' bill*

Direct payments or out-of-pocket expenditures account for a decreasing proportion of expenditures for physician services. Direct expenditures for physician services decreased from 63 percent in 1965 to 35 percent in 1975. This decrease was accounted for by the advent of medicare and medicaid and the increasing coverage of physician services under private health insurance.

During that span, the proportion of physician services paid by public sources increased greatly, from 6 percent to 27 percent. Private insurance benefits accounted for 31 percent of the payments for physician services in 1965 and 39 percent in 1975.



Source: Mueller, Marjorie Smith and Robert M. Gibson. "National Health Expenditures, Fiscal Year 1975." *Social Security Bulletin*, February 1976, U.S. Department of Health, Education, and Welfare.

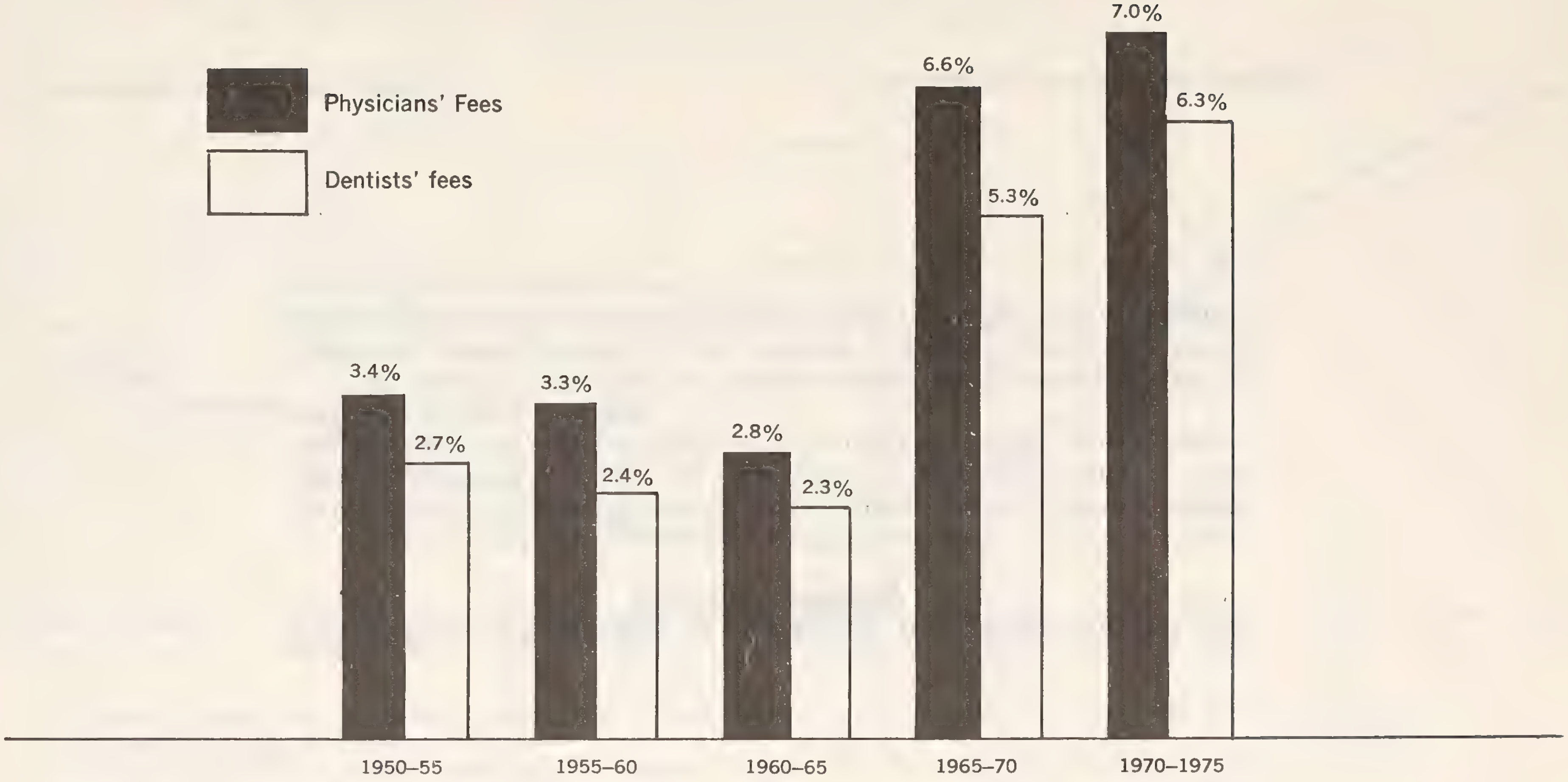
## CHART 3i.—*Dental fees have risen at about the same rate as physicians' fees*

Since 1950, dental and physician fees have risen at about the same rate with the increases for dentists being slightly smaller.

During 1950–65, dentists' fee increases averaged 2.5 percent annually and physicians' fees averaged 3.2 percent. Those increases are significantly higher than the 1.8 average annual percentage increase in the CPI for "all items."

During 1965–70, the annual rate of increase for dentists' fees was 5.3 percent and 6.6 percent for physicians' fees. Fee increases dropped the next two years during the Economic Stabilization Program, and rose again in 1975 to a record 10.3 percent for dentists' fees and 12.3 for physicians' fees.

AVERAGE ANNUAL PERCENTAGE INCREASE



Source: *Medical Care Expenditures, Prices, and Costs: Background Book*, Office of Research and Statistics, Social Security Administration, Department of Health, Education, and Welfare, September, 1975.

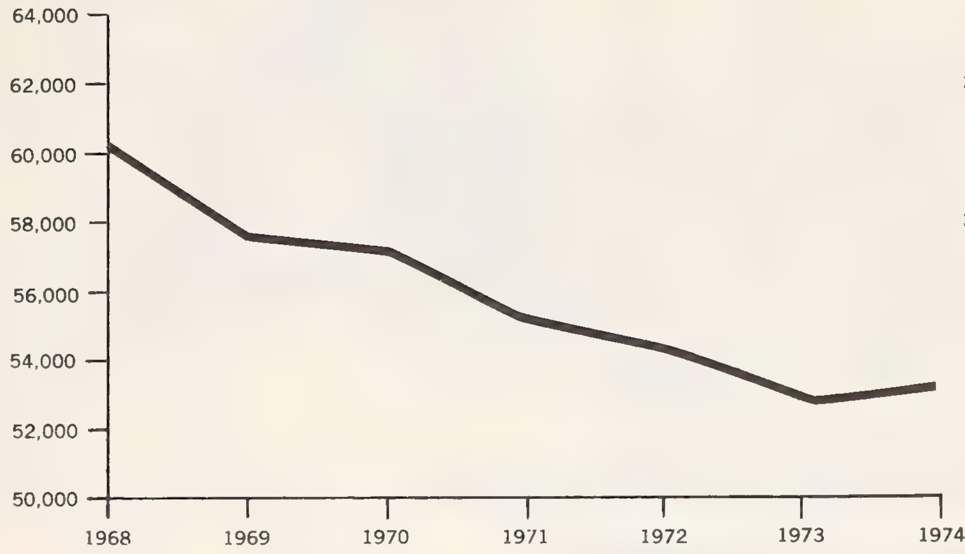
Monthly Statistical Report: Summary of Selected Price, Cost, and Utilization Data for the Health Care Market in the United States, Office of Health, Research and Statistics, Social Security Administration, Department of Health, Education, and Welfare, December 1975–January 1976.

## CHART 3j.—*The number of physicians in specialty practice has increased steadily*

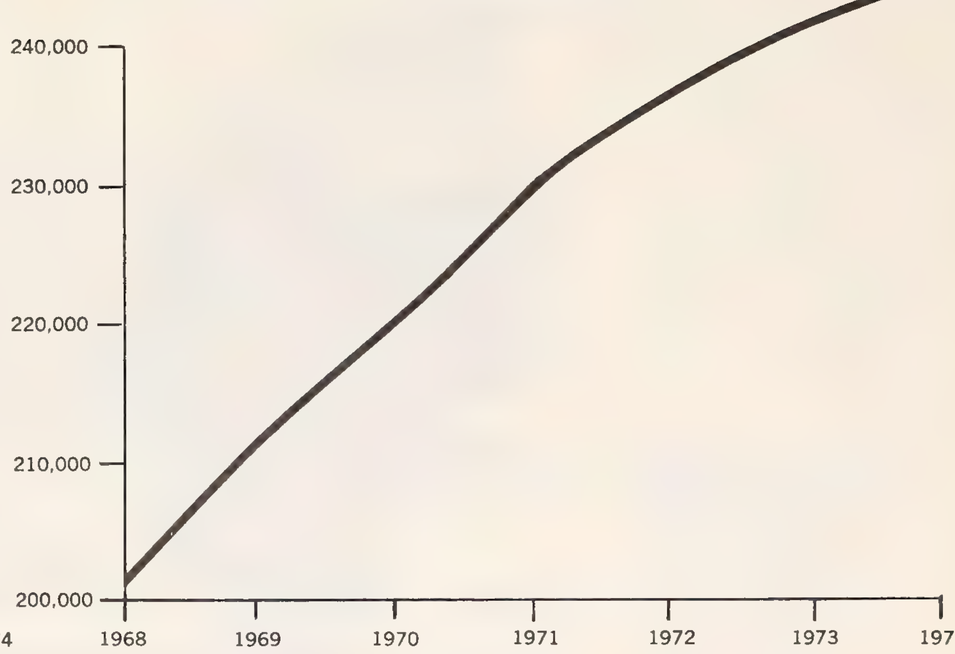
Of the 301,238 active physicians involved in patient care in the United States, over 248,300 (or 82 percent) are practicing in one or more specialty areas. Only 53,000 physicans (or 18 percent) are general practitioners. This compares with 201,000 specialists (or 79 percent) and 60,000 general practitioners (or 23 percent) in 1968.

The specialty attracting the largest number of physicians—52,000 in 1974—was internal medicine. It was followed by general surgery with 31,000 physicians and psychiatry with over 23,000. These specialities have consistently been the largest three since 1968.

**PHYSICIANS IN GENERAL PRACTICE**



**PHYSICIANS WITH MEDICAL SPECIALTY**



Source: Roback, G. A., *Physician Distribution and Medical Licensure in the U.S., 1974*, Center for Health Services Research and Development, American Medical Association.

Roback, G. A., et. al., *Distribution of Physicians in the U.S.*, 1973, 1972, 1971, 1970, 1969. Center for Health Services Research and Development, American Medical Association.

Roback, G. A., et. al., *Reclassification of Physicians, 1968*. Center for Health Services Research and Development, American Medical Association, 1971.

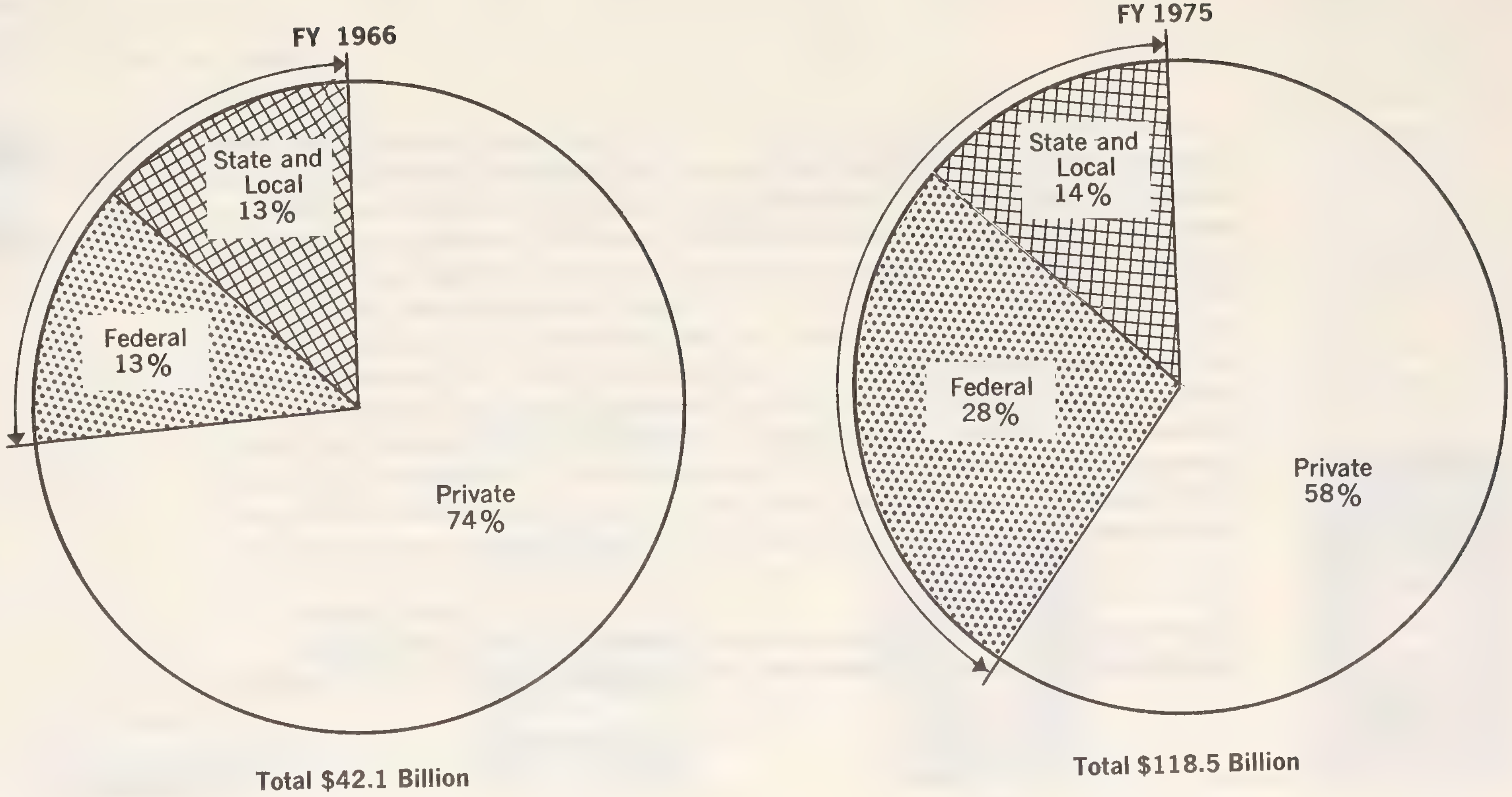
# Chapter 4. The Third-Party Payers

## CHART 4a.—*The Government pays about 42 cents out of every dollar for national health expenditures*

Medical care is financed both publicly and privately. The private share has always been by far the largest. But in recent years there has been a shift to more public financing because of the medicare and medicaid programs.

In fiscal 1966, the government at all levels spent 26 cents of every medical care dollar. Within the public sector, State and local governments were spending about the same amount as the Federal Government. The advent of medicare and medicaid together with the increasing expenditures under the public programs changed these relationships. By fiscal 1975, the government's portion had reached 42 cents, with much of this increasing share coming from Federal funds.

## NATIONAL HEALTH EXPENDITURES



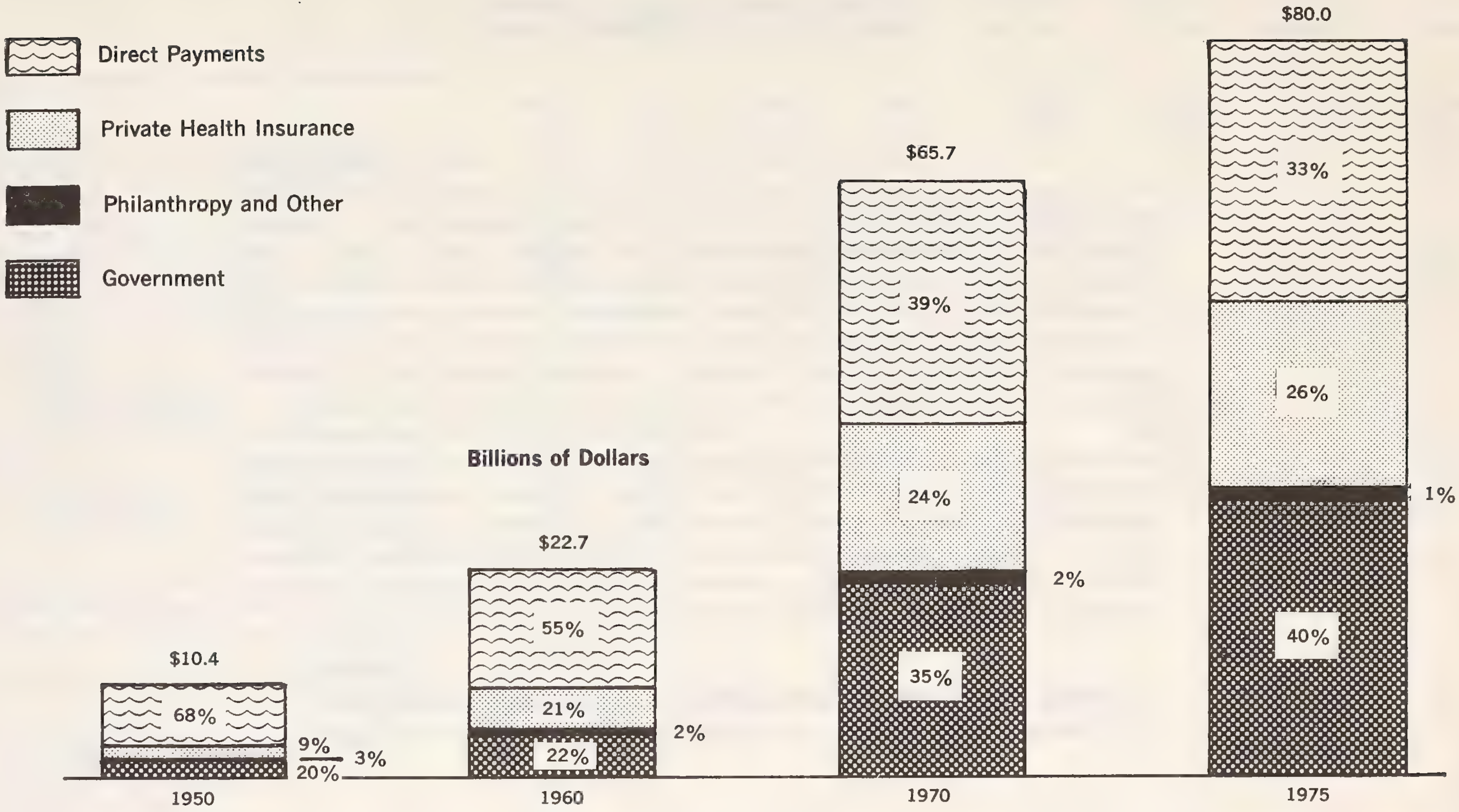
Source: Mueller, Marjorie Smith and Robert M. Gibson. "National Health Expenditures, Fiscal Year 1975." *Social Security Bulletin*, February 1976, U.S. Department of Health, Education, and Welfare.

### CHART 4b.—*The proportion of personal health care expenditures paid by third-party payers has increased significantly since 1950*

The distribution of personal health care expenditures by payment source has changed considerably in the past 25 years. In fiscal 1950, the sources and shares were as follows: direct payments by patients (68 percent), Federal-State-local governments (20 percent), private health insurance (9 percent), and philanthropy and others (3 percent). In the 1950's, private health insurance grew substantially so that by fiscal 1960, the governmental share was 22 percent, private health insurance paid 21 percent, and something over half came out of the individual's pocket.

With the implementation of medicare in 1966, a number of changes occurred in the source of payment for health care services. By fiscal 1975, the Government proportion had risen to 40 percent, the share held by private health insurance advanced to 26 percent, and the burden on the individual was further reduced to 33 percent.

## PERSONAL HEALTH CARE EXPENDITURES



Source: Mueller, Marjorie Smith and Robert M. Gibson. "National Health Expenditures, Fiscal Year 1975." *Social Security Bulletin*, February 1976, U.S. Department of Health, Education, and Welfare.

## CHART 4c.—*Federal expenditures for health are increasing rapidly and account for a significant portion of the Federal budget*

Outlays for Federal activities which have health as their primary purpose and are classified under the health function of the Federal budget were an estimated $27.6 billion in fiscal year 1975. This represents an increase of $5.6 billion or 2.5 percent over 1974. These activities include programs which finance and provide health services (primarily for the aged and the poor), support health research, pay for the training of health care personnel, and support the prevention and control of health problems.

The special analysis of the President's budget accounts for health-related outlays of the Federal budget in a different manner. The special analysis provides a distribution of Federal spending for all health activities even though the activity has a primary purpose that is not assigned to the health function. For example, medical care for military personnel is under the defense function in the budget but is included as a health-related expenditure in the special analysis. When accounted for in this manner, all Federal health-related expenditures totaled $36.8 billion in 1975 representing 11.3 percent of the total Federal budget.

## FEDERAL OUTLAYS FOR MEDICAL AND HEALTH-RELATED ACTIVITIES BY AGENCY, 1975

[In millions of dollars]

| | Health research | Training and education | Construction | Health planning activities | Direct Federal hospital and medical services | Indirect Federal hospital and medical services | Prevention and control of health problems | Total |
|---|---|---|---|---|---|---|---|---|
| Department of Health, Education, and Welfare (total) | 1,867 | 928 | 542 | 162 | 255 | 23,002 | 639 | 27,396 |
| Health Services Administration | 9 | 28 | 48 | 11 | 208 | 578 | 153 | 1,035 |
| Health Resources Administration | 58 | 528 | 369 | 126 | | 6 | 12 | 1,099 |
| Alcohol, Drug Abuse, and Mental Health Administration | 114 | 152 | 31 | | 43 | 515 | 96 | 950 |
| Center for Disease Control | 42 | 2 | | | | | 111 | 154 |
| National Institutes of Health | 1,598 | 177 | 82 | | | | 33 | 1,889 |
| Food and Drug Administration | 27 | | 1 | | | | 172 | 201 |
| Assistant Secretary for Health | 4 | | 2 | 21 | 4 | 11 | 2 | 45 |
| Social Security Administration | | | | | | 14,781 | | 14,781 |
| Medicare: | | | | | | | | |
| Hospital insurance | | | | | | (10,611) | | |
| Medical insurance | | | | | | (4,170) | | |
| Social and Rehabilitation Service | 2 | | | 1 | 1 | 6,876 | | 6,879 |
| Other HEW | 13 | 42 | 9 | 3 | | 235 | 59 | 361 |
| Department of Defense | 104 | 231 | 96 | | 2,261 | 567 | 26 | 3,285 |
| Veterans' Administration | 93 | 198 | 122 | 22 | 3,018 | 211 | | 3,665 |
| Department of Housing and Urban Development | | | 164 | 38 | | 1 | | 203 |
| Department of Agriculture | 47 | | 1 | | | | 259 | 307 |
| Environmental Protection Agency | 20 | | | | | | | 20 |
| National Aeronautics and Space Administration | 59 | | | | | | 3 | 62 |
| Energy Research and Development Administration | 143 | | 6 | | | | 95 | 244 |
| Department of Labor | 1 | 9 | | | | | 81 | 91 |
| Department of State | | 7 | | 12 | | 1 | 24 | 44 |
| National Science Foundation | 44 | | | | | | | 44 |
| Department of the Interior | 35 | | 3 | | | 8 | 2 | 48 |
| Department of Transportation | 15 | 2 | | 10 | 9 | | 23 | 60 |
| Department of Justice | | | 3 | | 23 | 3 | 3 | 32 |
| Other agencies | 31 | 8 | 13 | 71 | | 40 | 77 | 239 |
| Agency contributions to employee health funds | | | | | | 1,050 | | 1,050 |
| **Total outlays for health, 1975** | **2,459** | **1,384** | **949** | **316** | **5,567** | **24,883** | **1,232** | **36,790** |

Source: The Budget of the U.S. Government, fiscal year 1977.

## CHART 4d.—*Blue Cross-Blue Shield, commercial companies, and independent organizations provide health insurance coverage*

The private health insurance industry is made up of three broad categories of private health insurance organizations: Blue Cross and Blue Shield, commercial insurance companies, and independent plans.

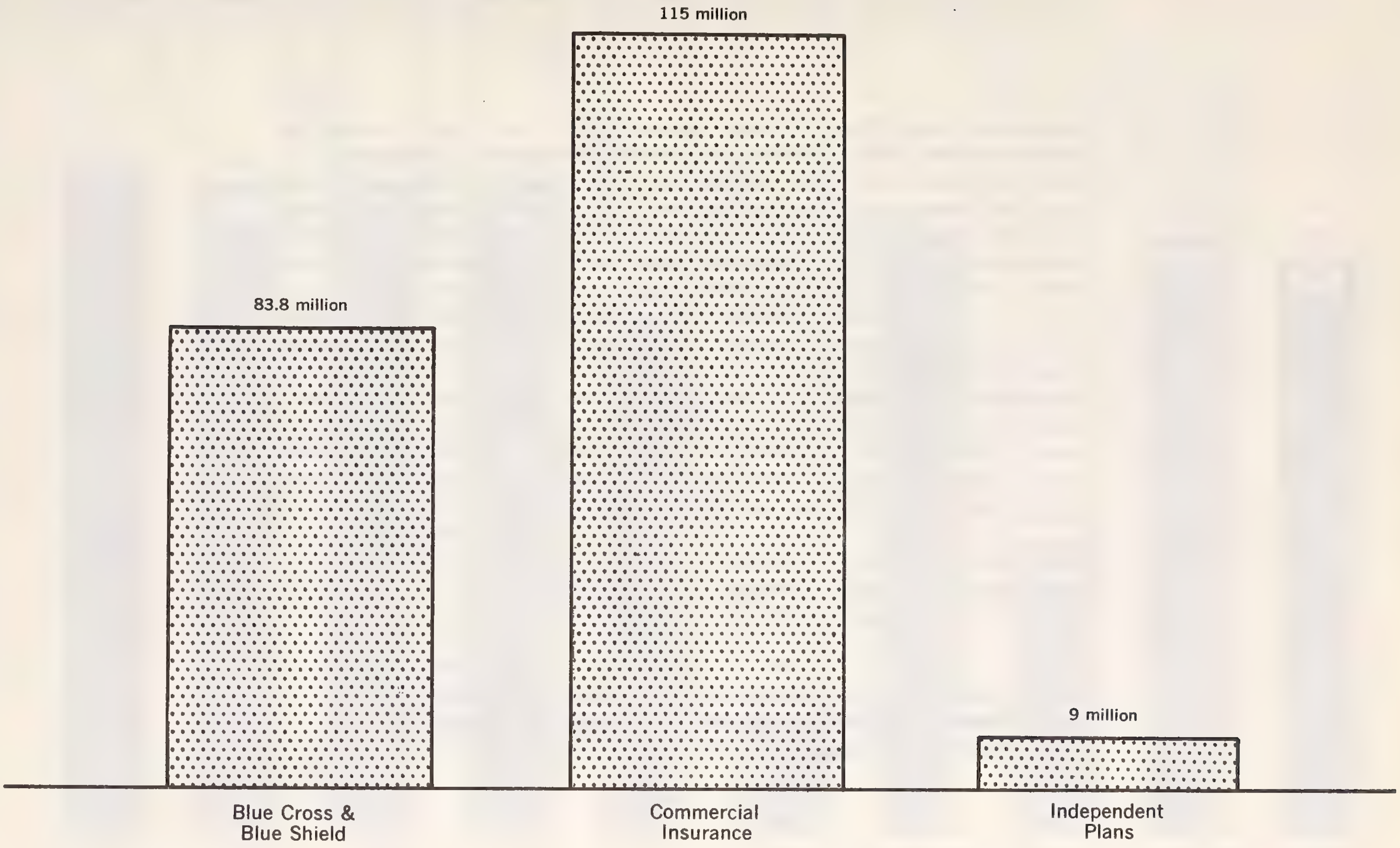
There are 74 Blue Cross plans covering about 82 million persons for hospital care and 72 Blue Shield plans insuring about 73 million persons for medical and surgical care. Together they cover about 84 million different people. Blue Cross-Blue Shield are nonprofit corporations serving the general communities of which they are a part.

About 1,000 commercial insurance companies write group and individual health insurance policies covering 115 million persons for hospital care.

There are about 500 independent plans with 9 million persons enrolled. Among these are community plans that generally are nonprofit plans serving a given area or consumer group, usually through group practice. Employer-employee-union plans serve selected groups of employees or union members and are operated by jointly managed union-employer welfare funds, employers, employee benefit associations, or unions. Some provide benefits through group practice arrangments. Private group clinics are operated by physicians or dentists on a private basis, organized as a partnership or an association; the majority serve most of their patients on a fee-for-service basis. Dental service corporations are nonprofit organizations. They provide service benefits on a free-choice-of-dentist basis.

How many persons are insured under more than one type of coverage is not known.

## NUMBER OF ENROLLEES FOR HOSPITAL BENEFITS AS OF DECEMBER 31, 1974



Source: Mueller, Marjorie Smith, and Paula A. Piro. "Private Health Insurance in 1974: A Review of Coverage, Enrollment, and Financial Experience," *Social Security Bulletin*, U.S. Department of Health, Education and Welfare, March 1976.

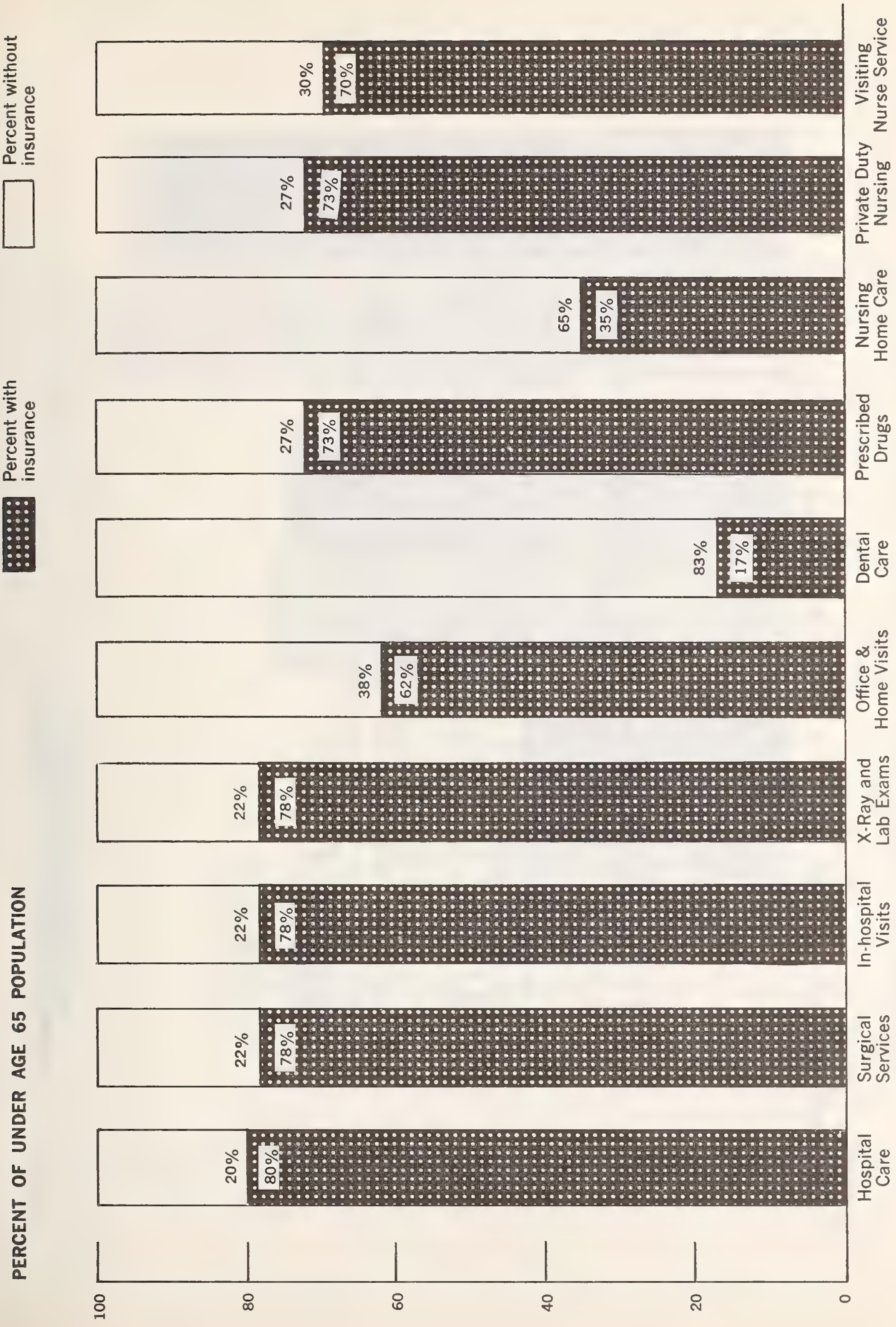
## CHART 4e.—*Almost four-fifths of the under-age-65 population has hospital and surgical insurance, but for many other health services insurance covers half or less of the under-65 population*

The post-World War II development of fringe benefits through collective bargaining and the growth of union-management health and welfare funds have been major forces in the tremendous growth of voluntary health insurance in the United States.

At the end of 1974, almost four-fifths of the population under age 65 had either hospital or surgical health insurance or both. Eighty percent had hospital coverage; 78 percent had some protection against surgical costs, 78 percent were covered at least in part for in-hospital-associated physician services, 78 percent were covered for X-ray and laboratory examinations; 62 percent for office and home physician visits and 73 percent for out-of-hospital prescription drugs (both subject to deductibles and other limitations), 35 percent for nursing home care; and 17 percent for dental care.

About 20 percent of the civilian population under age 65 (representing some 47 million persons) were still wholly unprotected in 1974. Disproportionate numbers of these were chidren and the poor. Medicaid protection applied to about 19.5 million people in poor families with children in fiscal year 1974, and an additional 2.5 million blind and disabled poor people were so covered.

The percent of people aged 65 and over who had private health insurance was generally much lower, largely because of their coverage under the medicare program.

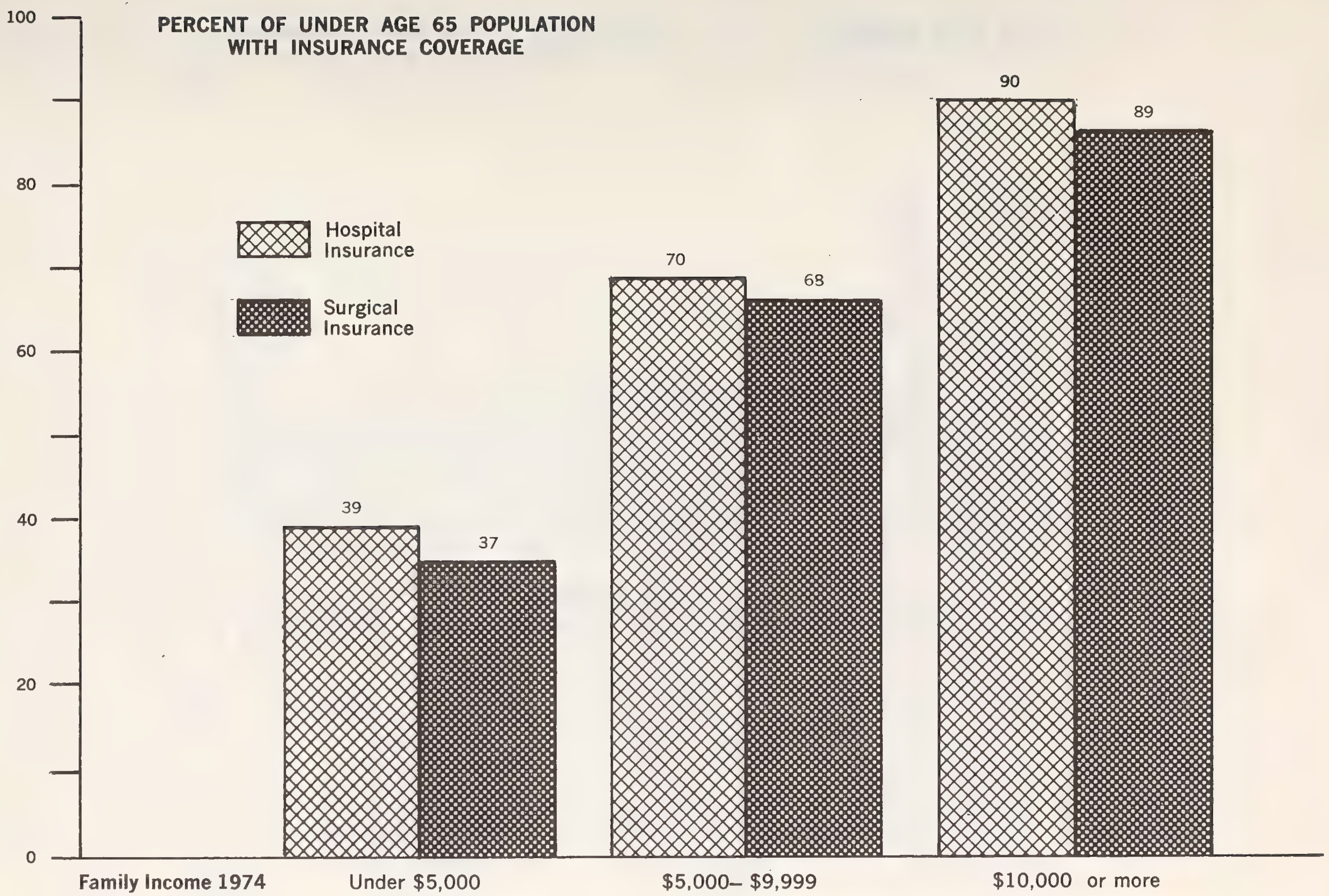


Source: Mueller, Marjorie Smith and Paula A. Piro, "Private Health Insurance in 1974: A Review of Coverage, Enrollment, and Financial Experience," *Social Security Bulletin*, U.S. Department of Health, Education, and Welfare, March 1976.

## CHART 4f.—*The poorer a person, the less likely he is to have health insurance*

The lower a person's family income, the less likely he is to have health insurance. In 1975, the proportion of persons under age 65 with hospital coverage was over 2 times less for those in the under $5,000 income bracket than for those in the $15,000-or-more groups. Only 39 percent of persons in families with incomes of less than $5,000 had some insurance protection against hospital bills.

As with hospital insurance, the income of one's family probably is the most important factor in determining whether one has surgical insurance. Only a little more than one-third of the poor compared with almost nine-tenths of those in the $10,000-plus income bracket had surgical insurance.



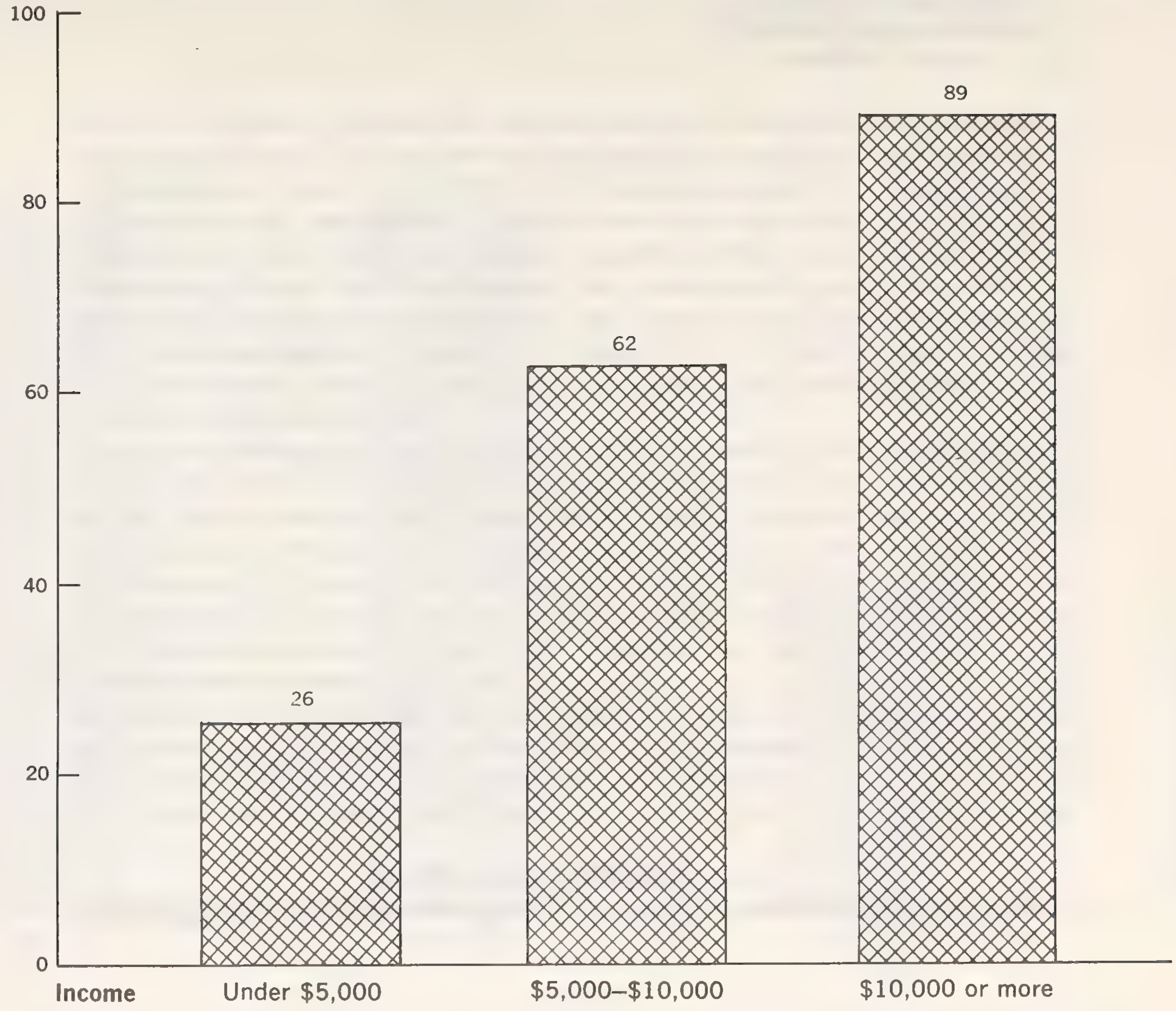
Source: *Health Interview Survey, 1974*, Division of Health Interview Statistics, National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

## CHART 4g.—*Less than one-fourth of children who are poor have hospital insurance*

Although the proportion of people with hospital insurance varies vastly by income the disparity by income is even greater for children. Among the poor, insurance protection for children under age 17 is scanty. Only about one-fourth of poor children had hospital insurance protection in 1974. The proportion is less than two-thirds for children in families with incomes of $5,000–$9,999, and rises steadily thereafter.

PERCENT OF UNDER AGE 17 POPULATION
WITH HOSPITAL INSURANCE

CALENDAR YEAR 1974



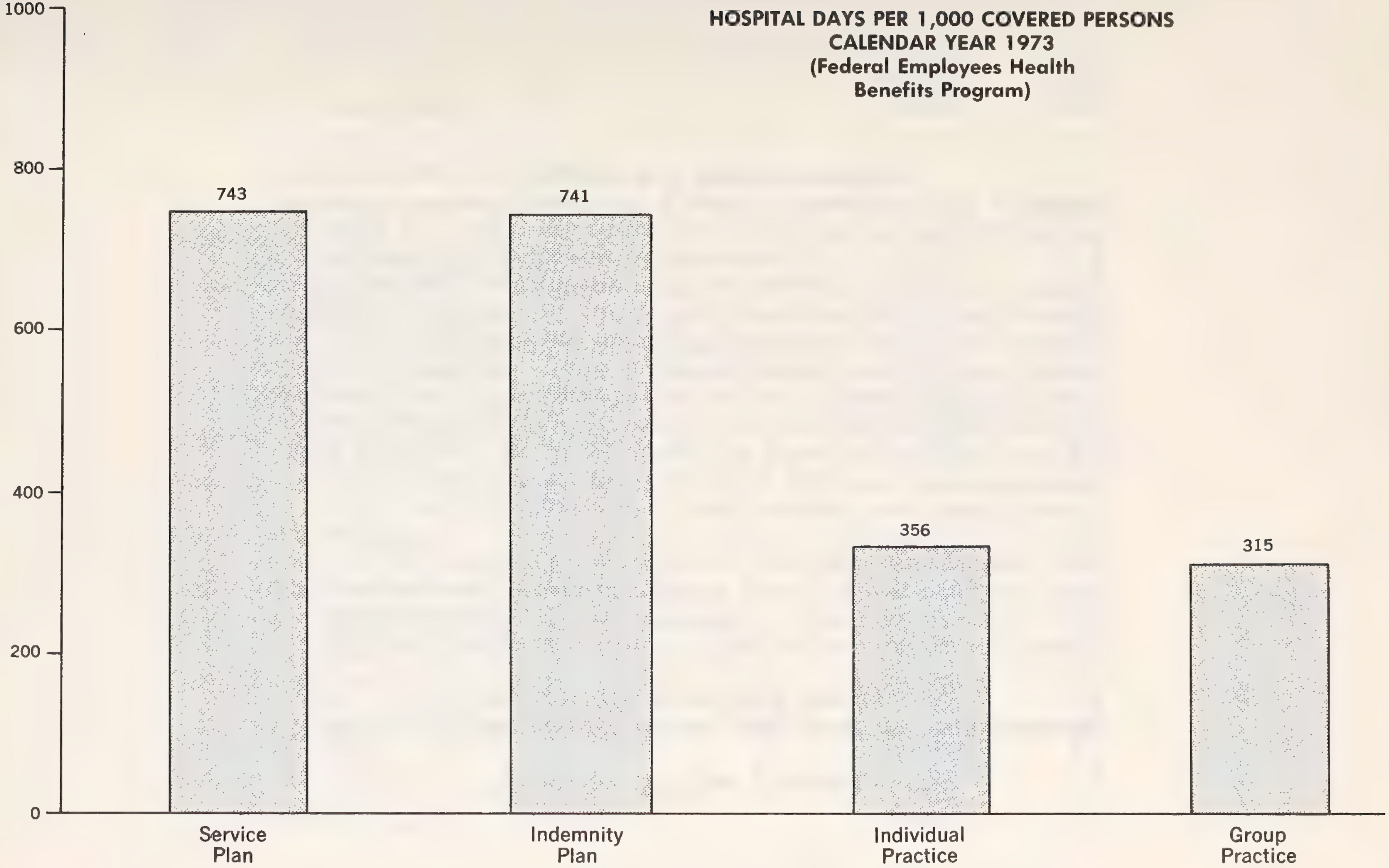
Source: *Health Interview Survey, 1974*. National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

## CHART 4h.—*People enrolled in prepaid group practice arrangements use hospitals less*

There has been widespread belief that most types of insurance coverage encourage overutilization of hospitals. The experience under the Federal Employees Health Benefits Program has provided useful data by which it is possible to test the validity of this generalization by comparing hospital use under various methods of insuring.

Enrollees in group practice plans in the Federal employee program are hospitalized less than half as many days as those in the nationwide service plan provided by Blue Cross-Blue Shield, and the nationwide indenmity plan provided by Aetna. Enrollees in individual practice plans also have a low utilization rate for hospital care. The individual practice plan includes physicians, usually paid on a fee-for-service basis, who practice in separate locations and who have contracted as individual physicians for care of the enrolled Federal employees and their families.

Considerable emphasis is now focused on promoting prepaid group practice plans as a more effective approach to health care. In 1973 Congress enacted the Health Maintenance Organization Act, under which Federal assistance is made available for the establishment and expansion of health maintenance organizations throughout the country. Those prepaid plans which provide certain basic and supplementary health care services in return for a basic and supplementary health service payment per enrollee made on a periodic basis and without regard to the date the services are provided or the frequency, extent, or nature of the services actually furnished, are eligible for assistance.



**HOSPITAL DAYS PER 1,000 COVERED PERSONS**
**CALENDAR YEAR 1973**
**(Federal Employees Health**
**Benefits Program)**

Source: *Medical Care Expenditures, Prices, and Costs: Background Book*, Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, September 1975.

# Chapter 5. The Patient

## CHART 5a.—*Heart disease, cancer, and stroke now cause nearly seven-tenths of all U.S. deaths*

Advances in medical knowledge and technology as well as the achievement of a high standard of living have lowered the U.S. death rate by nearly a half in this century alone. Because of improved methods of prevention and treatment, 4 of the 10 major killers in 1900 are no longer listed among major causes of death in 1973.

Of the remaining illnesses which have persisted, three—heart disease, cancer, and stroke—together caused nearly 70 percent of all deaths in the United States that year. Heart disease and cancer, in fact, now cause 2½ times as many deaths per 100,000 people as they did at the turn of the century. Much of this rise, however, must be attributed to the increase in life expectancy which has accompanied progress in medical research. More and more people now live to an advanced age and thus become more vulnerable to such disorders as heart diseases and stroke, which strike most heavily among persons aged 45 and over. Heart disease itself was responsible for almost two-fifths of all deaths in 1973, killing over 750,000 people.

Among the younger age groups, most people who die before age 35 are victims of accidents or some form of violence. Two-thirds of all accidental deaths occurring from age 1 through 35 involve automobiles.

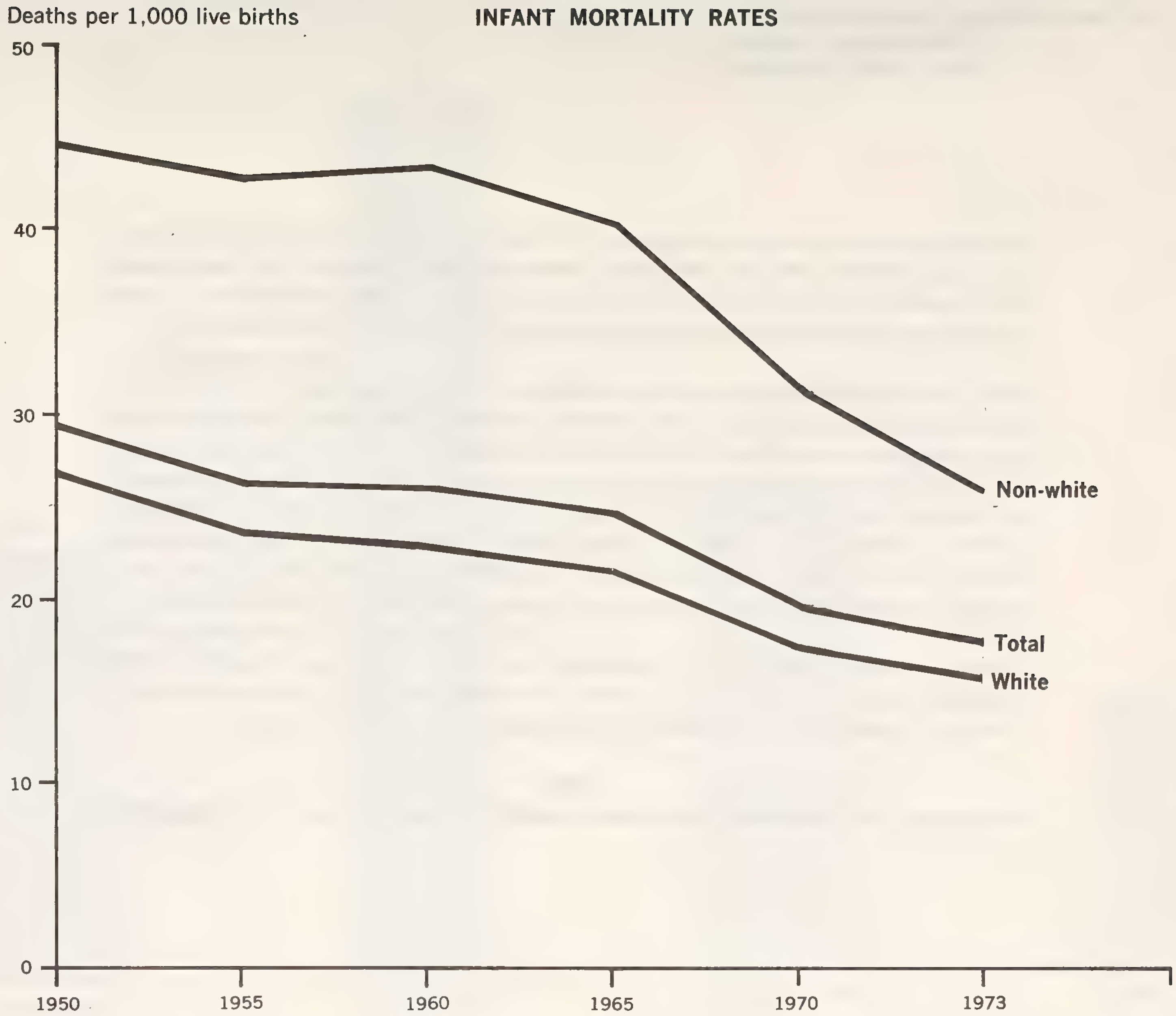
| Cause of death | Deaths per 100,000 persons | Percent of all deaths |
|---|---|---|
| **1900** | | |
| All causes | 1,719.1 | 100.0 |
| Influenza and pneumonia | 202.2 | 11.8 |
| Tuberculosis (all forms) | 194.4 | 11.3 |
| Gastritis, etc | 142.7 | 8.3 |
| Diseases of the heart | 137.4 | 8.0 |
| Vascular lesions affecting central nervous system | 106.9 | 6.2 |
| Chronic nephritis | 81.0 | 4.7 |
| All accidents | 72.3 | 4.2 |
| Malignant neoplasms (cancer) | 64.0 | 3.7 |
| Certain diseases of early infancy | 62.6 | 3.6 |
| Diphtheria | 40.3 | 2.3 |
| **1973** | | |
| All causes | 940.2 | 100.0 |
| Diseases of the heart | 360.8 | 38.4 |
| Malignant neoplasms | 167.3 | 17.8 |
| Cerebrovascular diseases | 102.1 | 10.9 |
| Accidents | 55.2 | 5.9 |
| Influenza and pneumonia | 29.8 | 3.2 |
| Certain diseases of early infancy | 14.5 | 1.5 |
| Diabetis mellitus | 18.2 | 1.9 |
| Cirrhosis of liver | 15.9 | 1.7 |
| Arteriosclerosis | 15.5 | 1.6 |
| Bronchitis, emphysema, and asthma | 14.2 | 1.5 |
| All other causes | 146.7 | 15.6 |

Source: "*Progress in Health Services,*" vol. 10, No. 2, February 1961. "*Vital Statistics Report, Annual Summary for the United States, 1963*". U.S. Department of Health, Education, and Welfare, National Center for Health Statistics.

## CHART 5b.—*On a national basis, infant mortality rates have been declining, but the nonwhite rate remains one and a half times the rate for whites*

In 1973 the estimated infant mortality rate for the entire U.S. population was 17.7 per 1,000 live births. In 1950 this rate was 29 per 1,000 live births. Between 1950 and 1973 the Nation thus experienced a 39-percent decline in its infant mortality rate.

When these rates are examined by race, improvements are indicated for both whites and non-whites. In 1950 the infant mortality rate for whites was 27 per 1,000 live births; in 1973 this rate had declined to 16. For nonwhites, the infant mortality rate in 1950 was 44.5 per 1,000 live births. By 1973 this rate had decreased to 26 deaths for every 1,000 live births. Despite this improvement, the rate for nonwhites was almost twice as high as the rate for whites.



Source: *Statistical Abstract of the United States*. Bureau of the Census, U.S. Department of Commerce, 1975.

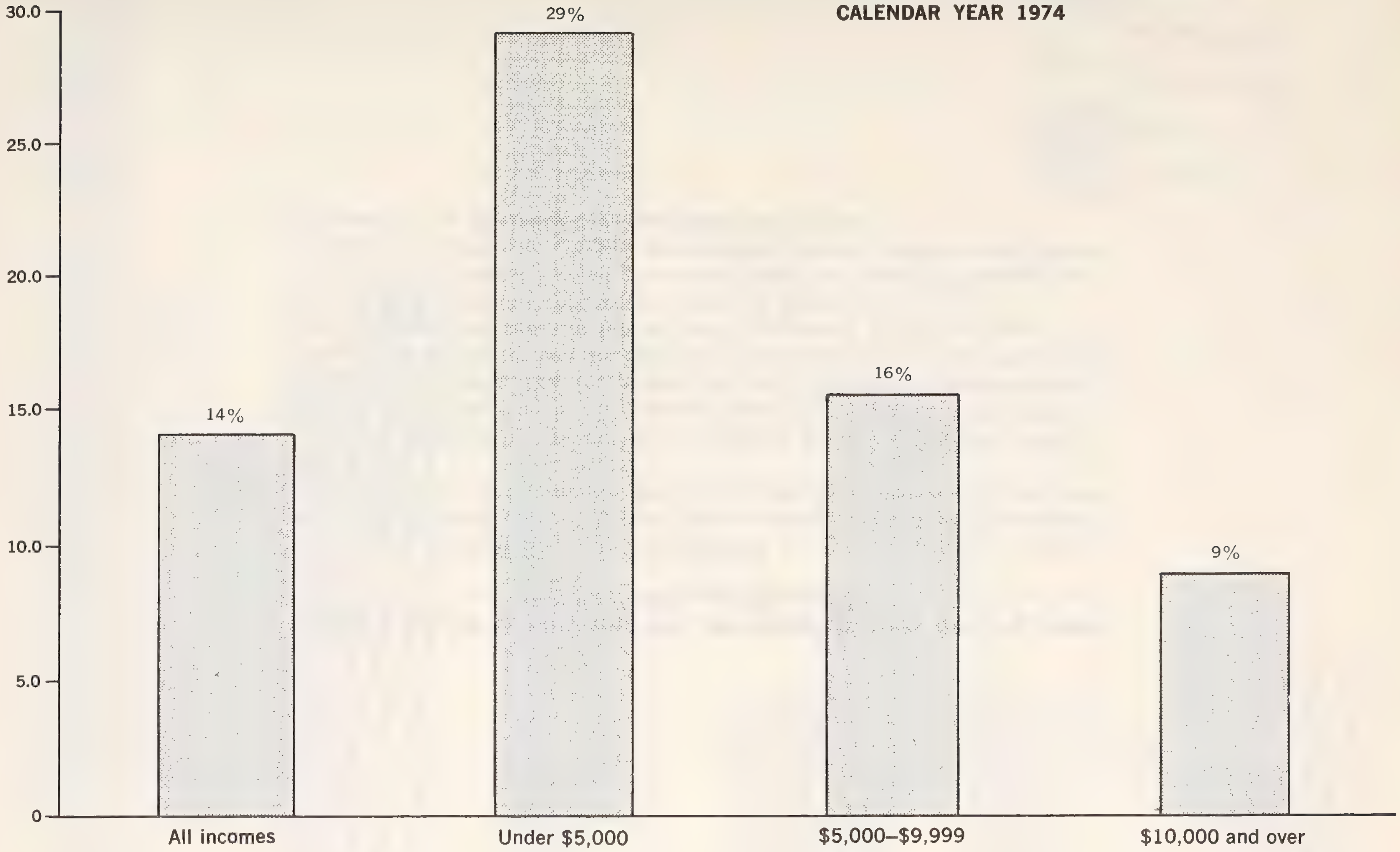
## CHART 5c.—*People with higher incomes are healthier than the poor*

No morbidity statistics are available comparing U.S. experience with that of other countries. There are, however, indices pointing up the extent of illness in our country. One such index is the proportion of the population with chronic conditions causing activity limitation.

In fiscal 1974, 14 percent of the population fell into this category. However, within this and other categories of health status in the United States, the inequalities are dramatic. Viewing activity-limitation by family income level, it is evident that the poor are much sicker than the nonpoor. Almost 30 percent of all the people with family incomes under $5,000 had activity-limiting chronic conditions. The proportion of the population with these conditions falls as income rises. People in the poorest income class were three times as likely to have an activity-limiting chronic condition as those in the highest income class ($10,000 and over).

The higher rates among the poor are partly due to the larger number of aged in this group. But even within each age group, the poor are consistently sicker than the nonpoor. And, of course, they may be poor because they are sicker and unable to hold a job or obtain a job which yields a substantial income.

### PROPORTION OF POPULATION WITH ACTIVITY-LIMITING CHRONIC CONDITIONS
### CALENDAR YEAR 1974



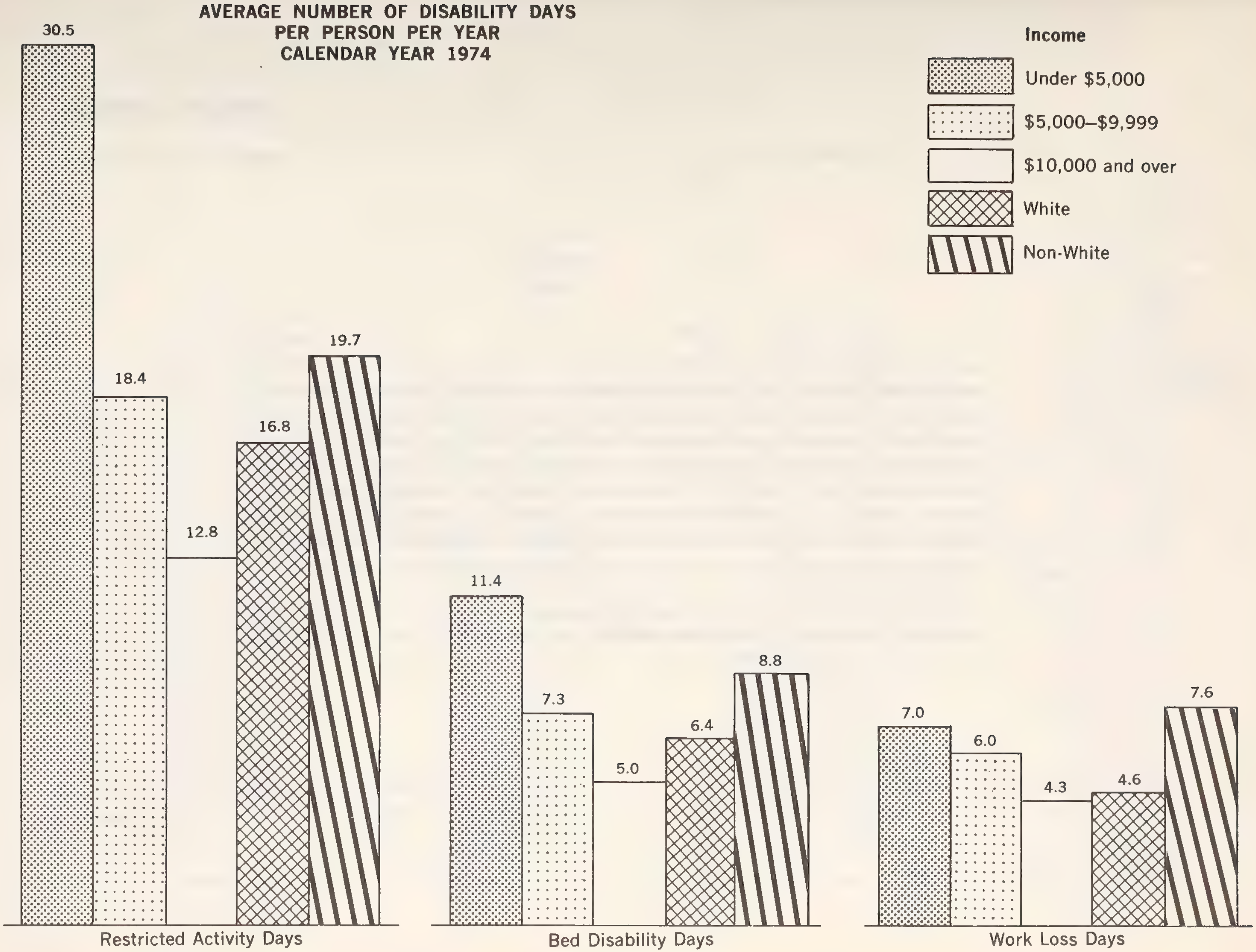
Source: *Health Interview Survey, 1974*, National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

## CHART 5d.—*The poor and the nonwhite are less healthy than the well-off and the white*

Another index of morbidity is the number of days each person is disabled in a year. In fiscal year 1974, each person averaged 17.2 days of restricted activity and 6.7 bed disability days. Each employed person lost 4.9 days from work.

When adjusted by age and sex, the number of days of restricted activity for members of households with incomes under $5,000 was 30.5 per person a year, compared with 12.8 for persons in the $10,000-plus income category. The per capita rate for bed disability days was 11.4 for the poor—well above the 5.0 average for those in families with incomes of $10,000 or more. The rates for days lost from work were 7.0 and 4.3, respectively.

Within the lowest income groups are people who are sick because they are poor and others who are poor because they are sick. In either case, illness is responsible for disability days and diminished incomes.



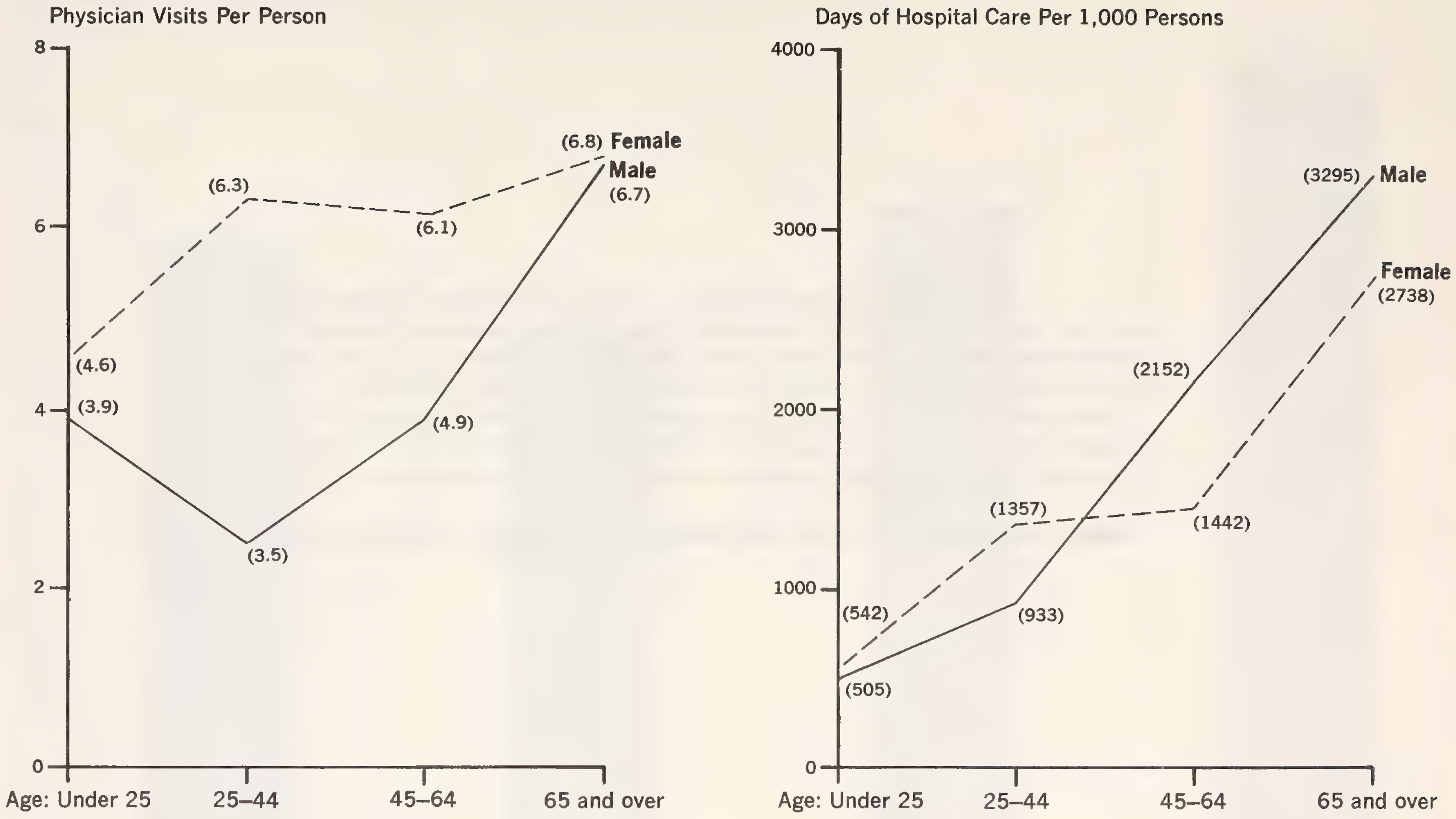
AVERAGE NUMBER OF DISABILITY DAYS
PER PERSON PER YEAR
CALENDAR YEAR 1974

Source: *Health Interview Survey, 1974*, National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

## CHART 5e.—*Utilization of physician and hospital services varies by sex*

When the Nation's utilization of physician and hospital services is examined by age and sex, patterns in utilization can be observed. For Americans under 45 years of age, females are shown to utilize both physician and hospital services at significantly higher rates than males at the same ages. This pattern is not unexpected, given the greater demand for medical care by women during their child-bearing years. It is only after the age of about 45 when rates of utilization of services by men begin to increase that physician visits per person and days of hospitalization for both sexes become comparable, with women using somewhat more physician services and men somewhat more inpatient hospital services.

## CALENDAR YEAR 1974


Physician Visits Per Person

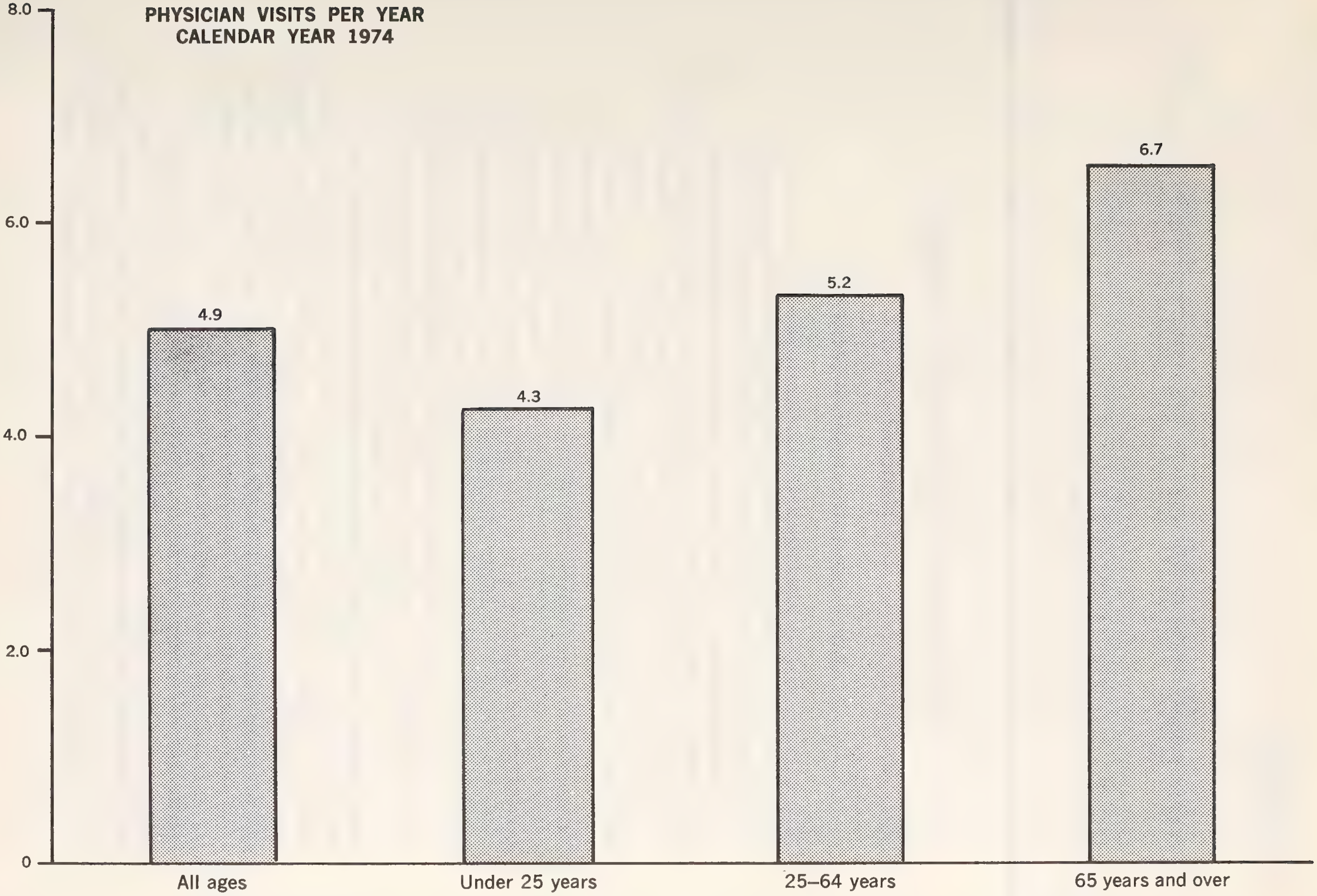
Days of Hospital Care Per 1,000 Persons

Source: *Health Interview Survey, 1974*, National Center for Health Statistics, Department of Health, Education, and Welfare.

## CHART 5f.—*People see physicians more as they grow older*

The average person saw a physician 4.9 times during 1974. The number of physician visits increases with advancing age. Frequency rates ranged upward from 4.3 visits for persons under age 25 to 6.7 visits for those 65 and over.

Utilization rates are high among older people because they are ill more often and for longer periods of time than those in the younger age groups. In addition, financial relief through medicare for persons aged 65 and over helps them to afford, and therefore to seek, physicians' services.



PHYSICIAN VISITS PER YEAR
CALENDAR YEAR 1974

Source: *Health Interview Survey, 1974*, National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

# PART II

# Characteristics of the Major Segments of the Health Care Industry

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## Chapter 1. Health Care Institutions

### Hospitals

### A. KEY FACTS ABOUT HOSPITALS (1974)

- There were 7,174 hospitals with 1,512,684 beds.
- Of these, 5,875 were short-term community hospitals, 589 were psychiatric or tuberculosis, 387 were Federal, 221 were other long-term or special hospitals, and 102 were hospital units of other institutions.
- Admissions to community hospitals totaled 32,865,867, or about 1 admission for each 6 residents of the United States (up 16 percent since 1969).
- Community hospitals employed 2.28 million full-time equivalent personnel.
- Community hospital employees per 100 adjusted patient census was 290 (up from 226 in 1960).
- Average salary of employees in community hospitals was $7,787 (up 44.8 percent over the $5,379 average for 1969).
- Expense per adjusted patient day in community hospitals reached $113.55 (up 76.7 percent over the $64.26 figure for 1969).
- 775 community hospitals with 69,600 beds (out of 925,996 beds in all community hospitals) were organized for profit.

The 7,174 domestic hospitals constituted one of the Nation's largest industries in 1974, with a total capacity of 1.51 million beds and overall assets approximating $51.7 billion. As a rough measure of this industry's output, hospitals handled some 35.5 million admissions and more than 250 million outpatient visits at a total expense of more than $41.4 billion. They employed 2.92 million full-time equivalent employees with a total payroll of more than $23.8 billion.

The hospital industry represents a mix of both the public and private sectors. Thirty-eight percent of all hospitals are publicly owned; they supply 50.2 percent of the bed capacity in the Nation's domestic hospitals. State hospitals are the largest in terms of average bed size, followed in ranking by Federal, voluntary nonprofit, local government, and for-profit hospitals.

Public hospitals receive their operating revenue from different sources. Federal hospitals and, to a lesser extent, State and local government hospitals, operate largely on funds budgeted by Government agencies. Private hospitals generally receive their revenue directly from the patient or from third-party payers (including private insurance carriers) and public programs such as medicare and medicaid

Hospitals can be classified into four groups representing a special type of care: psychiatric, tuberculosis, short-term general and other special, and long-term general and other special. Short-term general and other special hospitals, which contain 61.1 percent of all beds (67.7 percent of the beds in the case of non-Federal institutions), provide highly intensive care for a wide range of acute disorders. Consequently, they require relatively large numbers of employees and an array of highly sophisticated equipment. Long-term care hospitals, on the other hand, are bigger units, providing much less intensive care for chronic conditions which cannot be corrected quickly. As a result, they use fewer employees and usually do not have as much of the sophisticated diagnostic and therapeutic services and equipment likely to be found in short-term hospitals.

## COMMUNITY HOSPITALS

In order to consider that segment of the hospital industry which provides general medical care to the public as a whole, it is necessary to focus on the short-term general and other special hospitals, and to exclude psychiatric hospitals, tuberculosis hospitals, long-term general and other special hospitals, and Federal hospitals. In addition, a small component of the short-term general and other special hospitals grouping—hospital units of other institutions (such as prison and college infirmaries)—must be excluded. The remaining hospitals referred to as community hospitals, are defined as all non-Federal short-term general and other special hospitals, excluding hospital units of institutions, whose facilities and services are available to the public. Community hospitals represent about 82 percent of all hospitals, handle over 92 percent of all admissions and 75 percent of all outpatient visits, employ 78 percent of the industry's total labor force and account for 79 percent of the total cost of hospital care.

Bed capacity of community hospitals totaled about 926,000 in 1974—45 percent above the 1960 level. In terms of beds per 1,000 population, community hospital beds during the same period have increased from 3.59 to 4.41. Admissions and patient days per 1,000 population in 1974 were 156.7 and 1,217, respectively. Outpatient visits were 901.0 per thousand population.

## NONCOMMUNITY HOSPITALS

On the other hand, noncommunity hospital beds have decreased markedly—from 1,019,000 in 1960 to 586,688 in 1974. This decrease is a reflection of changes in medical technology. Significant discoveries were made which shortened the treatment of many conditions previously requiring long-term care—particularly in psychiatric and tuberculosis hospitals.

## HOSPITAL PRICE AND COST INFLATION

Hospital price and cost inflation can be measured in various ways. Rates of change in hospital *prices* can be measured by the Bureau of Labor Standards semiprivate room charge index. This index, a component of the Consumer Price Index, refers to the average daily charge for room and board and routine nursing care in semiprivate accommodations. All special services, such as drugs, tests, blood, and use of the operating room intensive and care units, are excluded. Since the semiprivate room charge index reflects only charges for a portion of hospital services, it will accurately reflect changes in overall prices only if the weighted average of all other prices increases at the same rate. As yet no comprehensive hospital price index exists for which historical data are available.

Comprehensive measures of hospital *cost* inflation, on the other hand, are available; the American Hospital Association's average expenses per patient day and per admission. The average expense per patient day is an estimate of the total cost of a day of hospital care. It is an aggregate figure derived by dividing total expenses (including outpatient and other expenses not attributable to inpatient care) by the number of adult and pediatric (not newborn) patient days. Expenses incurred by inpatients but not billed by the hospital, such as physicians' fees for treatment, are also excluded.

The problem of dividing by an output figure (i.e., inpatient days) which excludes outpatient care can be alleviated by a variant of this measure called average expense per adjusted patient day. For this measure total expenses are divided by adjusted patient days in which patient days are added together with the patient-day equivalents of outpatient visits. For example, if the value of an inpatient day is four times the value of an outpatient visit, then four visits will be equal (in terms of effort required) to 1 inpatient day. Adjusted patient days would then equal patient days plus one-fourth of the number of outpatient visits.

Another measure of cost inflation is the average expense per admission derived by dividing total expense by the number of admissions. This represents the cost per case. A similar correction for the exclusion of outpatient visits is required to get the average expense per adjusted admission—if the value of one admission is 30 times the value of one outpatient visit, then adjusted admissions are derived by adding admissions and one-thirteith of the number of outpatient visits.

The following table shows the values of the various measures since 1950 and the rates of increase for several periods. The difference between the rate of change in expense per day and expense per admission results from changes in length of stay. Because length of stay has been falling since 1969, the rate of change of expense per admission is somewhat lower than the rate for expense per day.

| Year | Hospital semiprivate room charges | Total expense per patient day | Expense per adjusted patient day | Expense per admission | Expense per adjusted admission |
|---|---|---|---|---|---|
| | Index or amount | | | | |
| 1950 | 30. 3 | $15. 62 | (1) | $127. 23 | (1) |
| 1955 | 42. 3 | 23. 12 | (1) | 179. 79 | (1) |
| 1960 | 57. 3 | 32. 23 | (1) | 244. 54 | (1) |
| 1961 | 61. 1 | 34. 98 | (1) | 267. 38 | (1) |
| 1962 | 65. 3 | 36. 83 | (1) | 281. 44 | (1) |
| 1963 | 68. 6 | 38. 91 | $35. 11 | 298. 10 | $269. 15 |
| 1964 | 71. 9 | 41. 58 | 37. 58 | 321. 28 | 285. 97 |
| 1965 | 75. 9 | 44. 48 | 40. 56 | 345. 65 | 310. 79 |
| 1966 | 83. 5 | 48. 15 | 43. 66 | 382. 05 | 337. 54 |
| 1967 | 100. 0 | 54. 08 | 49. 46 | 447. 64 | 409. 04 |
| 1968 | 113. 6 | 61. 38 | 55. 80 | 519. 21 | 471. 30 |
| 1969 | 128. 8 | 70. 03 | 64. 26 | 587. 99 | 539. 25 |
| 1970 | 145. 4 | 81. 01 | 73. 73 | 668. 67 | 610. 10 |
| 1971 | 163. 1 | 92. 31 | 83. 43 | 743. 15 | 675. 01 |
| 1972 | 173. 9 | 105. 21 | 94. 87 | 830. 13 | 749. 47 |
| 1973 | 182. 1 | 114. 49 | 102. 44 | 895. 83 | 799. 03 |
| 1974 | 201. 5 | 127. 81 | 113. 55 | 992. 42 | 885. 69 |
| | Average annual percentage increase | | | | |
| 1950–74 | 8. 2 | 9. 2 | (1) | 8. 9 | (1) |
| 1950–60 | 6. 6 | 7. 5 | (1) | 6. 8 | (1) |
| 1960–65 | 5. 8 | 6. 7 | [2] 7. 5 | 7. 2 | [2] 7. 5 |
| 1965–70 | 13. 9 | 12. 7 | 12. 7 | 14. 1 | 14. 4 |
| 1965–67 | 14. 8 | 10. 3 | 10. 4 | 13. 8 | 14. 7 |
| 1967–69 | 13. 5 | 13. 8 | 14. 0 | 14. 6 | 14. 8 |
| 1969–71 | 12. 5 | 14. 8 | 13. 9 | 12. 4 | 11. 9 |
| 1971–73 | 5. 7 | 11. 4 | 10. 8 | 9. 8 | 8. 8 |
| 1973–74 | 10. 7 | 11. 6 | 13. 2 | 10. 8 | 10. 8 |

[1] Not available.

[2] Average annual percentage increase from 1963 to 1965.

Source: Charges data are from the "*Consumer Price Index*," Bureau of Labor Statistics. Expenses data are from *Hospital Statistics 1974*, American Hospital Association, 1975.

In addition, costs are higher where occupancy rates are low. If a hospital is used more intensively, then fixed costs can be distributed over more patients, thus reducing the average cost. Finally, costs may be higher where hospitals are larger. Bigger hospitals tend to provide more specialized services and facilities than smaller hospitals. They also tend to treat more difficult cases, thus raising the average cost.

### ECONOMIC STABILIZATION PROGRAM

In August 1971, the President ordered a 90-day freeze on prices, wages, salaries, and rents and the creation of a Cost of Living Council to administer the freeze and to advise on further economic stabilization policies. Three months later, phase II of the economic stabilization Program (ESP) began. The ESP goal was to reduce the rate of inflation to about one-half of the pre-freeze rate. Because of the special problems of inflation in the health care industry, a special advisory panel was established to assist the Council in the health area. In December 1971, specific mandatory phase II rules were promulgated for the health care industry, rules which were continued for the industry when the phase III, or voluntary control program, began in January

1973. Modified controls (phase IV) were imposed on the health industry in June 1973. Price controls over the health industry (and certain other segments of the economy) ended in April 1974.

The prices of all goods and services in the economy, including medical care prices, have jumped appreciably since the lifting of price controls in April 1974. On an annualized basis, all consumer prices, less medical care, rose by 9.3 percent for the postcontrol period ending in September 1975. Medical care prices rose at an annualized rate of 12.6 percent.

*Annualized rate of increase in medical care prices* (*pre-ESP*, *total ESP*, *and post-ESP periods*)

| Index | Pre-ESP, fiscal years 1966–71 | Total ESP, (August 1971–April 1974 | Post-ESP, April 1974–September 1975 |
|---|---|---|---|
| CPI (less medical care) | 4. 3 | 6. 5 | 9. 3 |
| Medical care | 6. 5 | 4. 3 | 12. 6 |
| Hospital charges (semiprivate room) | 14. 6 | 5. 7 | 18. 2 |
| Physician fees | 6. 9 | 4. 0 | 12. 8 |
| Dentist fees | 5. 7 | 4. 2 | 10. 3 |

## HOSPITAL USE

Like most other characteristics of the hospital industry, average length of stay varies by area, from a low 6.5 days in Mountain and Pacific census divisions to 9.3 days in the Middle Atlantic census division. Patterns of medical practice differ from State to State regarding admission and discharge policies and utilization review practices. The incidence of different kinds of disease differs from one area to another as does the age distribution of the population. In sparsely populated areas where people must travel far for medical care, minor cases may be hospitalized to avoid repeat visits, resulting in shorter stays. Economic characteristics such as income levels and insurance coverage also have important impact. Hospitals with high occupancy rates may postpone elective admissions, yielding a case-mix composition with relatively longer stays.

Length of stay also differs according to the type of hospital. Average length of stay was 7.7 days in State and local short-term hospitals, 7.9 days in nonprofit hospitals and 6.7 days in for-profit hospitals during 1974.

## FINANCIAL POSITION OF HOSPITALS

Annual net incomes of nonprofit and for-profit hospitals increased from $29 million in 1950 to $547 million in 1971 (the latest year for which comparable data are available). On a patient-day basis, net income for all nongovernmental community hospitals during that period rose from 29 cents to nearly $3. These trends are a result of several factors. Private hospitals have been used more intensively since 1965 than during earlier periods. Both the extent and level of insurance coverage have increased, resulting in more stable incomes for hospitals and lower losses due to bad debts and charity. Medicare and medicaid apparently contributed significantly to these improvements.

Considerable differences have continually existed between for-profit hospitals, which earned $6.43 per patient day in 1971, and nonprofit hospitals, which earned $2.63 (as shown below). This differential results mainly from the fact that nonprofit hospitals are larger, provide more specialized and expensive services and facilities, and probably serve a slightly different patient population than for-profit hospitals.

| Year | Net income per patient day | | |
|---|---|---|---|
| | Total | Nonprofit | For profit |
| | Amount | | |
| 1950 | $0.29 | $0.17 | $1.36 |
| 1955 | .50 | .37 | 2.25 |
| 1960 | 1.01 | .93 | 2.11 |
| 1965 | 1.70 | 1.55 | 3.57 |
| 1967 | 2.31 | 2.12 | 4.74 |
| 1969 | 2.55 | 2.34 | 5.27 |
| 1970 | 2.55 | 2.24 | 6.36 |
| 1971 | 2.91 | 2.63 | 6.43 |
| | Average annual percentage increase | | |
| Period: | | | |
| 1950–71 | 11.6 | 13.9 | 7.7 |
| 1950–60 | 13.3 | 18.5 | 4.5 |
| 1960–65 | 11.0 | 10.8 | 11.1 |
| 1965–70 | 8.4 | 7.6 | 12.2 |
| 1965–67 | 16.6 | 17.0 | 15.2 |
| 1967–69 | 5.1 | 5.1 | 5.4 |
| 1969–71 | 6.8 | 6.0 | 10.5 |

Source: Hospitals, guide issues, Aug. 1, various years.

Plant assets of community hospitals totaled nearly $27.9 billion in 1974 an 1,000-percent increase over the value in 1950. When converted to plant assets per average daily census or assets required per unit of output, the rate of growth is reduced to 532 percent. This percentage increase, however, overstates the growth of real assets required per unit of output.

### SOURCE OF FINANCING

While hospital care expenditures have been rapidly increasing, the source of financing for this care has been changing. Medicare and medicaid have been taking over more and more of the private burden of paying for hospital care.

In fiscal 1966, the year before medicare, the private sector contributed 64 percent of the $14.2 billion bill for hospital care. The Federal Government had a 13-percent share, and State-local governments paid the remaining 23 percent.

Preliminary estimates for fiscal year 1975 indicate that the private sector's share declined to 44.9 percent. Some of the State and local share had been shifted to the Federal Government so that by fiscal 1975, 39.2 percent came from Federal funds and 15.8 percent from State and local spending.

The proportion of hospital care expenditures paid by private insurance declined from 42 percent in fiscal 1966 to 35.4 percent in fiscal 1974.

## B. SELECTED CHARACTERISTICS OF FOR-PROFIT HOSPITALS—1974 *

### 1. NUMBER AND BEDS

The number of for-profit hospitals which serve as community hospitals has decreased over the period 1946 to 1974 from 1,076 to 775. Over that same period, however, the number of beds in such hospitals increased from 39,000 to 70,000. The number of voluntary nonprofit community hospitals increased from 2,584 to 3,355, with an increase in beds from 301,000 to 649,000 over the same period.

The range in size of for-profit hospitals serving as community hospitals compared with all community hospitals was as follows:

| Bed size | For-profit community hospitals | | All community hospitals | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Total | 775 | 100. 0 | 5, 775 | 100. 0 |
| Under 25 beds | 64 | 8. 3 | 308 | 5. 2 |
| 25 to 49 beds | 216 | 27. 9 | 1, 176 | 20. 0 |
| 50 to 99 beds | 239 | 30. 1 | 1, 504 | 25. 6 |
| 100 to 199 beds | 194 | 25. 0 | 1, 346 | 22. 9 |
| 200 to 299 beds | 47 | 6. 1 | 658 | 11. 2 |
| 300 and over | 15 | 1. 9 | 883 | 15. 0 |

Of the 775 non-profit community hospitals in 1974, 490 (64.0 percent) were accredited by the Joint Commission on Hospital Accreditation.

### 2. GEOGRAPHIC LOCATIONS

For-profit hospitals are concentrated in three areas in the United States, New York City and western Long Island, the Los Angeles area, and the rural South (see table 1 for regional breakdown).

A further analysis shows that of the 7,173 beds in short-term for-profit hospitals in New York State, the majority were in institutions in New York City and Nassau County and Suffolk County. Most of the remainder were located in other areas near New York City.

Of the 17,881 beds in California for-profit community hospitals, most were in institutions in Los Angeles and neighboring Orange County.

### 3. FINANCES AND PERSONNEL

The ratio of personnel to patients in for-profit hospitals has increased from 137 per 100 patients in 1946 to 283 per 100 patients in 1974. The comparable figures for nonprofit community hospitals ranged from 156 per 100 patients in 1946 to 323 in 1974. Thus, while there has been an increase in this ratio over the period 1946 to 1974 for-profit hospitals still lag behind the nonprofits.

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*Compiled from American Hospital Association data.

Total expenses of community for-profit hospitals have increased over the period 1946 to 1974 from $94 million to $2,046 million. Assets have also increased—the total assets for community for-profit hospitals in 1947 were $129,119,000; by 1974 the figure had reached $2,288 million.

The sources of capital formation for for-profit hospitals are roughly similar to other businesses: the savings of the entrepreneur, sale of stock, and borrowing. For-profit hospitals are not eligible for Government funds which can be used for capital development (other than as part of the reimbursement under medicare or medicaid). Nor do for-profit hospitals obtain funds through public subscription—hospital fund raising drives.

### 4. CHARACTERISTICS OF PATIENT LOAD

The occupancy rates for for-profit hospitals are lower than for nonprofit hospitals. Occupancy rates for for-profit hospitals ranged from 64.1 percent in 1946 to 67.5 percent in 1974; for nonprofits the rate ranged from 76.7 percent in 1946 to 77.9 percent in 1974. Not only are there more empty beds in for-profit hospitals but patients stay there for a shorter time. The average length of stay for for-profit community hospitals has shown very little change from 1946 to the present—6.6 days in 1946 and 6.7 days in 1974. The average stay in nonprofit hospitals in 1946 was 8.8 days and 7.9 days in 1974.

The shorter stays in for-profit hospitals may be accounted for by several factors. In some areas of the country, particularly in rural areas, a doctor may set up a "hospital" in connection with his office as a place where he can keep a closer watch on the patient, and provide nursing services more economically than if he had to visit the patient at home. However, in all likelihood he will still send his more seriously ill patients to a larger hospital in a nearby city or town. In such cases, the patients in the for-profit hospitals would not, as a group, be as seriously ill as those in the nonprofit hospitals. There is also evidence that some for-profit hospitals restrict their admissions to patients with certain types of disorders or who need rather simple forms of surgery, tending to avoid the complicated cases with their longer stays.

In addition, it is likely that physicians in some areas who cannot, or do not wish to, gain staff privileges in a local nonprofit hospital have organized their own hospitals in which to care for their patients.

### 5. SERVICES OFFERED

On almost every count for-profit short-term hospitals offer a narrower range of services than do nonprofit hospitals. For example 61.0 percent of the nonprofit hospitals have pathology laboratories but only 43.2 percent of the for-profit hospitals have them. Similarly, 86.7 percent of the nonprofit hospitals have a postoperative recovery room; 80.5 percent of the for-profit hospitals have such facilities. More than 74 percent of the nonprofit hospitals have intensive care units while only about 57 percent of the for-profit hospitals have them.

### 6. PER PATIENT DAY COSTS

The per patient day cost for for-profit hospitals increased from $10.13 in 1946 to $119.81 in 1974. Such costs in nonprofit hospitals increased from $10.04 in 1946 to $127.24 in 1974. A number of factors which were discussed earlier contribute to the difference in per diem costs between the nonprofit and for-profit hospitals: The smaller range of services offered in the for-profit hospitals; the tendency in some for-profit hospitals to avoid admitting the more seriously ill patient; and the lower ratio of personnel to patients. These factors offset the effect on costs of the lower occupancy rates and shorter stays for the for-profit hospitals—which by themselves would produce higher per patient day costs. It should also be noted that the for-profit hospitals have been subject to the same economic conditions—population changes, increase in utilization, inflation, and increases in payroll and nonpayroll expenses which have produced the large increases in hospital costs in the past 20 years.

### 7. CONTROL

Table 2 details the for-profit hospitals in each State and indicates other pertinent data about the for-profit hospitals in each State.

TABLE 1.—*Regional distribution of for-profit hospitals and beds, 1974*

| Region | Hospitals | Beds |
|---|---|---|
| Total | 775 | 69,600 |
| New England | 7 | 829 |
| Middle Atlantic | 73 | 9,769 |
| South Atlantic | 121 | 12,494 |
| East North Central | 14 | 832 |
| East South Central | 75 | 7,240 |
| West North Central | 22 | 1,400 |
| West South Central | 230 | 15,863 |
| Mountain | 23 | 2,157 |
| Pacific | 210 | 19,016 |

TABLE 2.—*For profit short-term general and other special hospitals, 1974*

| State | Hospitals | Beds | Occupancy rate (percent) | Average stay (days) | Total assets (thousands) |
|---|---|---|---|---|---|
| Alabama | 21 | 2,603 | 70.0 | 7.4 | $99,140 |
| Alaska | 0 | 0 | NA | NA | NA |
| Arizona | 9 | 706 | 64.7 | 6.7 | 23,031 |
| Arkansas | 13 | 700 | 70.1 | 5.9 | 14,230 |
| California | 192 | 17,881 | 60.9 | 6.1 | 673,858 |
| Colorado | 1 | 240 | 72.1 | 5.8 | 9,747 |
| Connecticut | 0 | 0 | NA | NA | NA |
| Delaware | 0 | 0 | NA | NA | NA |
| District of Columbia | 1 | 284 | 66.5 | 7.8 | 10,834 |
| Florida | 43 | 5,150 | 67.4 | 7.4 | 222,630 |
| Georgia | 21 | 1,900 | 63.6 | 5.7 | 61,416 |
| Hawaii | 1 | 30 | 60.0 | 5.8 | 610 |
| Idaho | 2 | 191 | 64.9 | 5.5 | 4,229 |
| Illinois | 10 | 699 | 60.1 | 6.6 | 17,665 |
| Indiana | 1 | 76 | 73.7 | 5.4 | 2,216 |
| Iowa | 3 | 87 | 64.4 | 6.7 | 591 |
| Kansas | 4 | 115 | 66.1 | 5.9 | 3,306 |
| Kentucky | 9 | 1,433 | 73.6 | 6.7 | 34,490 |
| Louisiana | 36 | 2,267 | 65.1 | 6.0 | 67,487 |
| Maine | 0 | 0 | NA | NA | NA |
| Maryland | 1 | 33 | 81.8 | 5.8 | 489 |

TABLE 2.—*For profit short-term general and other special hospitals, 1974*—Con.

| State | Hospitals | Beds | Occupancy rate (percent) | Average stay (days) | Total assets (thousands) |
|---|---|---|---|---|---|
| Massachusetts | 7 | 829 | 63.4 | 8.7 | 21,209 |
| Michigan | 1 | 18 | 55.6 | 4.6 | 560 |
| Minnesota | 0 | 0 | NA | NA | NA |
| Mississippi | 4 | 243 | 64.2 | 5.3 | 5,654 |
| Missouri | 13 | 1,127 | 69.0 | 6.8 | 27,844 |
| Montana | 3 | 65 | 60.0 | 5.5 | 1,534 |
| Nebraska | 1 | 43 | 32.6 | 7.1 | 289 |
| Nevada | 6 | 852 | 65.6 | 5.8 | 52,455 |
| New Hampshire | 0 | 0 | NA | NA | NA |
| New Jersey | 5 | 857 | 75.0 | 8.2 | 41,425 |
| New Mexico | 0 | 0 | NA | NA | NA |
| New York | 51 | 7,173 | 80.0 | 8.1 | 205,229 |
| North Carolina | 8 | 578 | 67.8 | 5.6 | 20,749 |
| North Dakota | 1 | 28 | 39.3 | 5.4 | 569 |
| Ohio | 1 | 6 | 33.3 | 1.0 | 122 |
| Oklahoma | 13 | 698 | 66.3 | 6.9 | 16,145 |
| Oregon | 10 | 666 | 55.9 | 5.5 | 22,081 |
| Pennsylvania | 17 | 1,739 | 75.3 | 8.0 | 50,277 |
| Rhode Island | 0 | 0 | NA | NA | NA |
| South Carolina | 5 | 224 | 82.1 | 5.8 | 6,244 |
| South Dakota | 0 | 0 | NA | NA | NA |
| Tennessee | 41 | 2,961 | 69.6 | 7.0 | 90,542 |
| Texas | 168 | 12,198 | 66.2 | 6.4 | 335,537 |
| Utah | 2 | 103 | 68.9 | 4.6 | 3,268 |
| Vermont | 0 | 0 | NA | NA | NA |
| Virginia | 24 | 2,769 | 79.1 | 7.5 | 81,329 |
| Washington | 7 | 439 | 56.3 | 4.5 | 12,836 |
| West Virginia | 18 | 1,556 | 71.7 | 6.5 | 45,049 |
| Wisconsin | 1 | 33 | 75.8 | 9.5 | 671 |
| Wyoming | 0 | 0 | NA | NA | NA |
| Total | 775 | 69,600 | 67.5 | 6.7 | 2,287,587 |

NA=Not available.

## C. EXPENSE PER ADJUSTED PATIENT DAY IN COMMUNITY HOSPITALS, BY STATE

Nationally, average expense per adjusted patient day in 1974 ranged from a low $62 in nonmetropolitan Minnesota to $190 in metropolitan Alaska. The cost level of hospital care is related to various factors. Costs tend to be higher where personal income is above average because hospitals must compete for labor in the local market. Costs also tend to be higher where length of stay is relatively short. Many of the expensive diagnostic tests used in present-day medical care are administered in the first day or two of a hospital stay; after that, ancillary costs decline. Thus the longer the patient stays, the lower his average cost per day.

In addition, costs are higher where occupancy rates are low. If a hospital is used more intensively, fixed costs can be distributed over more patients, thus reducing the average cost. Also, costs may be higher in large hospitals, since they usually provide more specialized services and facilities and tend to treat more difficult cases. Finally, costs will be higher where the number of outpatient visits is relatively low.

These factors help to explain differences in expense per adjusted patient day between and within States. Wide cost differences often exist between a State's metropolitan and nonmetropolitan areas. Urban hospitals incur higher costs because they are generally larger and provide more specialized services. In addition, they must pay higher wages to compete in the local labor market.

Differences in cost levels between regions of the country are similarly explained to some extent by these factors. Cost per day ranged from a low of $87.37 in the East South Central States to a high of $148.50 in the Pacific States with New England close behind at $138.14.

TABLE 3.—*Expense per adjusted patient-day by region and State, including metropolitan and nonmetropolitan areas, 1974*

| | Total | Metropolitan | Nonmetropolitan |
|---|---|---|---|
| United States | $113.55 | $123.61 | $81.86 |
| New England | 138.14 | 149.44 | 103.77 |
| Connecticut | 141.56 | 141.98 | 138.12 |
| Maine | 96.54 | 117.16 | 87.56 |
| Massachusetts | 152.33 | 157.67 | 115.42 |
| New Hampshire | 95.12 | 98.12 | 94.43 |
| Rhode Island | 133.61 | 135.72 | 113.52 |
| Vermont | 99.49 | N/A | 99.49 |
| Middle Atlantic | 123.69 | 128.78 | 85.56 |
| New Jersey | 109.58 | 110.16 | 98.89 |
| New York | 140.02 | 146.85 | 84.63 |
| Pennsylvania | 104.36 | 108.36 | 83.24 |
| South Atlantic | 103.49 | 114.02 | 80.00 |
| Delaware | 113.15 | 120.72 | 94.25 |
| District of Columbia | 146.38 | 146.38 | (1) |
| Florida | 113.13 | 115.42 | 97.12 |
| Georgia | 102.57 | 115.50 | 81.38 |
| Maryland | 130.44 | 136.01 | 100.65 |
| North Carolina | 88.18 | 102.82 | 73.06 |
| South Carolina | 86.45 | 101.92 | 71.78 |
| Virginia | 91.81 | 99.10 | 77.72 |
| West Virginia | 82.08 | 85.52 | 78.98 |
| East North Central | 111.99 | 119.96 | 81.77 |
| Illinois | 121.01 | 128.36 | 84.55 |
| Indiana | 95.43 | 100.35 | 83.07 |
| Michigan | 122.46 | 129.82 | 86.90 |
| Ohio | 107.36 | 112.15 | 82.68 |
| Wisconsin | 98.20 | 115.18 | 73.03 |
| East South Central | 87.37 | 97.12 | 73.43 |
| Alabama | 91.58 | 99.14 | 75.34 |
| Kentucky | 85.26 | 93.31 | 74.93 |
| Mississippi | 80.36 | 102.18 | 74.34 |
| Tennessee | 88.88 | 96.99 | 69.00 |
| West North Central | 92.20 | 106.24 | 75.57 |
| Iowa | 85.52 | 92.85 | 79.69 |
| Kansas | 87.02 | 107.45 | 71.18 |
| Minnesota | 98.06 | 114.16 | 62.33 |
| Missouri | 97.96 | 104.01 | 79.36 |
| Nebraska | 90.93 | 110.96 | 64.96 |
| North Dakota | 78.40 | 104.92 | 72.31 |
| South Dakota | 77.86 | 89.02 | 74.64 |
| West South Central | 96.83 | 103.39 | 78.18 |
| Arkansas | 82.27 | 91.79 | 72.26 |
| Louisiana | 103.03 | 108.69 | 85.59 |
| Oklahoma | 98.22 | 109.90 | 81.55 |
| Texas | 97.17 | 102.21 | 76.48 |
| Mountain | 111.16 | 127.03 | 84.12 |
| Arizona | 129.45 | 137.25 | 94.56 |
| Colorado | 111.74 | 121.38 | 83.82 |
| Idaho | 88.40 | 121.88 | 80.90 |
| Montana | 82.56 | 86.13 | 81.03 |
| Nevada | 142.41 | 150.47 | 97.59 |
| New Mexico | 103.23 | 131.83 | 83.13 |
| Utah | 110.27 | 116.23 | 78.69 |
| Wyoming | 84.55 | (1) | 84.55 |

Footnote at end of table.

TABLE 3.—*Expense per adjusted patient-day by region and State, including metropolitan and nonmetropolitan areas, 1974*—Continued

| | Total | Metropolitan | Nonmetropolitan |
|---|---|---|---|
| Pacific | 148. 50 | 153. 49 | 109. 57 |
| Alaska | 163. 04 | 189. 90 | 130. 78 |
| California | 155. 78 | 158. 15 | 120. 05 |
| Hawaii | 118. 19 | 124. 69 | 101. 66 |
| Oregon | 116. 82 | 127. 46 | 96. 61 |
| Washington | 125. 83 | 133. 17 | 104. 34 |

[1] Not available.

Source: Hospital Statistics, 1974.

## D. PSYCHIATRIC HOSPITALS

Between 1946 and 1962, the number of non-Federal psychiatric hospital beds in the United States steadily increased. Since then, however, the number of beds has declined from a peak of 717,000 to 383,000 in 1974. These beds are located in some 543 institutions throughout the country. Occupancy rates between 1946 and 1974 in psychiatric hospitals have declined—from 91.0 percent to 80.0 percent. New drugs, new therapy techniques, and alternatives to institutional care have contributed to this decline.

Though the demand for inpatient services in psychiatric hospitals has declined markedly over the last decade or so, the demand for outpatient services has dramatically increased. In 1962, outpatient visits to psychiatric hospitals amounted to 892,000; in 1974, the number of visits had reached 5,240,000.

TABLE 4.—*Non-Federal psychiatric hospitals, 1974*

| Hospital classification | Number | Beds | Occupancy (percent) | Outpatient visits |
|---|---|---|---|---|
| Total | 543 | 383, 480 | 80. 0 | 5, 240, 106 |
| Short-term, total | 137 | 11, 569 | 69. 3 | 1, 399, 618 |
| Nongovernmental, nonprofit | 44 | 2, 967 | 75. 8 | 434, 384 |
| For profit | 66 | 4, 169 | 65. 2 | 137, 669 |
| Local governmental | 4 | 667 | 55. 8 | 154, 309 |
| State governmental | 23 | 3, 766 | 71. 1 | 673, 256 |
| Long-term total | 406 | 371, 911 | 80. 3 | 3, 840, 488 |
| Nongovernmental, nonprofit | 44 | 5, 574 | 81. 3 | 335, 810 |
| For profit | 49 | 4, 615 | 76. 9 | 154, 637 |
| Local governmental | 16 | 9, 648 | 77. 5 | 178, 039 |
| State governmental | 297 | 352, 074 | 80. 4 | 3, 172, 002 |

Source: Hospital Statistics, 1974.

TABLE 5.—*Teaching hospitals*

| Hospital classification | Number | Medical and dental interns and residents | Other trainees | Total trainees |
|---|---|---|---|---|
| Total | 662 | 47, 250 | 14, 476 | 61, 726 |
| Nongovernmental | 519 | 28, 396 | 9, 959 | 38, 355 |
| Under 300 beds | 136 | 2, 459 | 516 | 2, 975 |
| 300 to 399 beds | 117 | 4, 167 | 1, 671 | 5, 838 |
| 400 to 499 beds | 96 | 4, 707 | 1, 338 | 6, 045 |
| 500 and over | 170 | 17, 063 | 6, 434 | 23, 497 |
| State and local government | 143 | 18, 854 | 4, 517 | 23, 371 |
| Under 300 beds | 39 | 1, 506 | 351 | 1, 857 |
| 300 to 399 beds | 24 | 1, 817 | 520 | 2, 337 |
| 400 to 499 beds | 23 | 2, 516 | 276 | 2, 792 |
| 500 and over | 57 | 13, 015 | 3, 370 | 16, 385 |

Source: Hospital Statistics, 1974.

## E. TEACHING HOSPITALS

In 1974 there were 662 community hospitals in the United States which had affiliations with medical schools and which conducted approved education programs for medical and dental interns and residents. The majority of these hospitals—78.4 percent—were nongovernmental facilities employing 672,138 personnel, including more than 10,700 physicians and dentists. The remaining institutions were owned or controlled by State and local governments, utilizing 239,473 persons of whom more than 8,770 were physicians and dentists. Nearly a quarter of all community teaching hospitals are located in the Middle Atlantic States of New Jersey, New York, and Pennsylvania.

During 1974, the teaching hospitals were training 47,250 medical and dental interns and residents and 14,746 other persons in trainee status.

## Nursing Homes

### INTRODUCTION

The term "nursing home" is a generic term covering a wide variety of institutions providing health care of various levels to people with health problems ranging from minimal to very serious [1] Nursing homes typically provide one or more of the following groupings of services:

(1) *Nursing care and related medical services.*—Nursing care provided or supervised by registered nurses and licensed practical nurses. Related medical services include physical therapy, occupational or speech therapy, dental services, medical social services, dietary consultation, laboratory and radiation services, and pharmaceutical services.

(2) *Personal care.*—Personal services and unskilled nursing services including assistance in walking, getting in and out of bed, bathing, dressing, eating, and preparation of special diets.

(3) *Residential care.*—Room, board, social programs, laundry facilities, and help with shopping, obtaining transportation and letter writing.

The medicare and medicaid programs cover a variety of nursing homes for several classes of people and patients as follows:

*Medicare.*—Medicare permits participation in that program of those nursing homes which meet the definition of "skilled nursing facility" under title XVIII of the Social Security Act. In addition, medicare has a set of requirements relating to prior hospitalization and levels of required care which result in coverage only for relatively short periods of time following hospitalization.

*Medicaid.*—All medicaid programs must cover services in "skilled nursing facilities" with the same definitions as that used in medicare. States can add to the minimum Federal requirements. States also set the eligibility conditions and any limits on the number of days covered. The average length of stay in a skilled nursing facility under medicaid is generally much longer than the average length of stay in a skilled nursing facility under medicare. Medicaid skilled nursing facility benefits are, of course, available only to the poor or medically needy.

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[1] The generic term "nursing home" is defined by the American College of Nursing Home Administrators as follows:

"A 'nursing home or its equivalent' is a facility, institution, or an identifiable unit of an acute hospital or other care service facility or institution licensed for:

"1. Care for persons who because of physical or mental conditions, or both, require or desire living accommodations and care which as a practical matter, can best be made available to them through institutional facilities, other than acute care units of hospitals, providing a protective and/or supervised environment, and

"2. Care of persons and patients who require a combination of health care services and personal care services which are in addition to the avove and may include, but are not necessarily restricted to, one or more of the following care services:

"(*a*) Therapeutic diets,

"(*b*) Regular observation of the patient's physical and mental condition,

"(*c*) Personal assistance including bathing, dressing, grooming, ambulation, transportation, housekeeping (such as bedmaking, dusting, etc.) of living quarters,

"(*d*) A program of social and recreational activities,

"(*e*) Assistance with self-administered medications,

"(*f*) Emergency-medical care including bedside nursing during temporary periods of illness,

"(*g*) Professional nursing supervision,

"(*h*) Skilled nursing care,

"(*i*) Medical care and services by a licensed practitioner,

"(*j*) Other special medical and social care services for diagnostic and treatment purposes of rehabilitative, restorative, or maintenance nature, designed to restore and/or maintain the person in the most normal physical and social condition attainable."

State medicaid programs can also cover care in "intermediate care facilities" (ICF's) a term defined in title XIX of the Social Security Act.

The care provided in intermediate care facilities is for patients who may need a broad spectrum of services ranging from those just above room and board up to the skilled nursing facility level.

The classification of various institutions described or named as nursing homes can become very confusing. For example, many institutions with the word "hospital" in their names are not hospitals but may be skilled nursing facilities or intermediate care facilities. Similarly, many nursing homes do not use the words in their names. A few general guidelines to the term are:

(1) Nursing homes are usually licensed as such by the States. (The States are required, under the medicaid program, to license administrators of nursing homes, but not administrators of hospitals. This difference may facilitate distinguishing between the two general types of institutions.)

(2) Skilled nursing facilities and intermediate care facilities are terms in specific government programs and include the concept of participation in those programs. A single institution may meet one or all of the definitions.

(3) In addition to facilities which provide some amount of nursing care there are facilities which provide only personal care or which provide residential services where nursing care in infrequent and intermittent or absent altogether.

(4) Categories of homes may vary markedly from one geographical area to another.

### NUMBERS OF NURSING CARE FACILITIES

There has been a substantial growth over the last 10 years in the numbers of nursing care facilities and beds in the United States. In 1963, for example it was estimated that nursing care facilities numbered 8,128 with a capacity of 319,224 beds. By 1973–74, facilities had increased by 93.2 percent to 15,700, while capacity grew by 268 percent to 1,174,800 beds.

TABLE 6.—*Nursing care facilities, 1963–74*

| Year or period | Facilities | Beds |
|---|---|---|
| | Number | |
| 1963 | 8, 128 | 319, 224 |
| 1967 | 10, 636 | 584, 052 |
| 1969 | 11, 484 | 704, 217 |
| 1971 | 12, 871 | 917, 707 |
| 1973–74 | 15, 700 | 1, 174, 800 |
| | Percentage increase | |
| 1963–1973–1974 | 93. 2 | 268. 0 |
| 1963–67 | 30. 9 | 83. 0 |
| 1967–69 | 8. 0 | 20. 6 |
| 1969–71 | 12. 1 | 30. 3 |
| 1971–73–74 | 22. 0 | 28. 0 |

Source: "Health Resources Statistics," Department of Health, Education, and Welfare, National Center for Health Statistics, selected years; and, "Selected Operating and Financial Characteristics of Nursing Homes, United States: 1973–74 National Nursing Home Survey." U.S. Department of Health, Education, and Welfare, Public Health Service; Vital and Health Statistics series 13–No. 22.

TABLE 7.—*Selected operating characteristics of nursing homes, 1973–1974*

| *Operating characteristics* | *All facilities* |
|---|---|
| Number of homes | 15,700 |
| Number of beds | 1,174,800 |
| Average bed size | 75 |
| Average total FTE employees per 100 beds | 63.9 |
| Nursing FTE employees per 100 beds | 38.7 |
| RN FTE employees per 100 beds | 4.4 |
| LPN FTE employees per 100 beds | 5.7 |
| Nurses' aide FTE employees per 100 beds | 28.6 |
| Administrative, medical, and therapeutic FTE employees per 100 beds | 4.6 |
| All other FTE employees per 100 beds | 20.6 |
| Number of residents | 1,075,800 |
| Number of resident days of care (1972) | 368,906,000 |
| Average occupancy rate (1972) | 88.2 |

Source: "Selected Operating and Financial Characteristics of Nursing Homes, United States: data from the 1973–74 National Nursing Home Survey," U.S. Department of Health, Education, and Welfare, Public Health Service, Vital and Health Statistics Series 13–Number 22.

In 1973–74, the average total monthly charge in nursing homes equalled $479. The average total cost per resident day was $15.63. Labor costs accounted for about three-fifths of a facility's average total costs, or $9.17 per resident day.

TABLE 8.—*Selected financial characteristics of U.S. nursing homes*

| | |
|---|---|
| 1973–1974 resident charges: | |
| Average total monthly charge per resident | $479 |
| Percent of homes by average total monthly charge per resident: | |
| Less than $299 | 17.8 |
| $300 to $399 | 28.1 |
| $400 to $499 | 25.3 |
| $500 to $599 | 14.9 |
| $600 or more | 13.9 |
| 1972 facility costs: | |
| Average total costs per resident day | $15.63 |
| Labor costs per resident day | 9.17 |
| Fringe benefit cost per resident day | 0.67 |
| Wage costs per resident day | 8.50 |
| Nursing staff costs per resident day | 5.36 |
| Other staff costs per resident day | 3.14 |
| Fixed costs per resident day | 2.37 |
| Operating costs per resident day | 3.41 |
| Food and drug costs per resident day | 1.60 |
| All other costs per resident day | 1.81 |
| Miscellaneous costs per resident day | 0.68 |
| Percent of homes by average total costs per resident day: | |
| Less than $10 | 23.0 |
| $10 to $14.99 | 36.3 |
| $15 to $19.99 | 22.9 |
| $20 or more | 17.8 |
| Percent of homes by average labor costs per resident day: | |
| Less than $4 | 8.5 |
| $4 to $7.99 | 41.8 |
| $8 to $11.99 | 32.0 |
| $12 or more | 17.7 |
| Percent of homes by average fixed costs per resident day: | |
| Less than $1 | 19.6 |
| $1 to $1.99 | 32.4 |
| $2 to $2.99 | 22.4 |
| $3 or more | 25.6 |
| Percent of homes by average operating costs per resident day: | |
| Less than $2 | 20.0 |
| $2 to $2.99 | 39.7 |
| $3 to $3.99 | 18.8 |
| $4 or more | 21.5 |
| Percent of homes by average miscellaneous costs per resident day: | |
| Less than $0.50 | 55.5 |
| $0.50 to $0.99 | 26.8 |
| $1 to $1.99 | 12.7 |
| $2 or more | 5.0 |

NOTE: Figures may not add to totals due to rounding.

SOURCE: "Selected Operating and Financial Characteristics of Nursing Homes, United States: 1973–74 National Nursing Home Survey." U.S. Department of Health, Education, and Welfare, Public Health Service, Vital and Health Statistics Series 13–Number 22.

A substantial majority of nursing homes are proprietary. In 1973–74, about 75 percent of all homes were operated on a for-profit basis. Proprietary homes had the greatest proportion, almost 71 percent, of all nursing home beds and served about 70 percent of all nursing home residents during that period.

TABLE 9.—*Selected operating characteristics of nursing homes by ownership classification, 1973–74*

| Operating characteristics | Proprietary | Nonprofit |
|---|---|---|
| Number of homes | 11, 900 | 3, 900 |
| Number of beds | 830, 700 | 344, 300 |
| Average bed size | 70 | 88 |
| Average total FTE employees per 100 beds | 57. 4 | 83. 5 |
| Nursing FTE employees per 100 beds | 36. 7 | 44. 1 |
| Administrative, medical, and therapeutic FTE employees per 100 beds | 4. 9 | 3. 8 |
| All other FTE employees per 100 beds | 15. 6 | 35. 5 |
| Number of residents | 756, 200 | 319, 700 |
| Number of resident days of care (1972) | 260, 449, 600 | 108, 456, 400 |
| Average occupancy rate (1972) | 88. 8 | 86. 5 |

Note: Figures may not add due to rounding.

Source: "Selected Operating and Financial Characteristics of Nursing Homes, United States: 1973–74 National Nursing Home Survey." U.S. Department of Health, Education, and Welfare, Public Health Service Vital and Health Statistics Series 13, No. 22.

In 1972, nonprofit nursing homes incurred greater costs than proprietary homes. Average total costs per resident day were about 20 percent more for non-profit homes, reflecting substantially higher costs for labor and nursing staff.

Resident charges were lower in nonprofit homes. In 1973–74, nonprofit nursing homes had an average monthly resident charge of $456 or 7.2 percent less than proprietary homes.

TABLE 10.—*Selected financial characteristics of nursing homes by ownership classification*

| | Proprietary | Nonprofit |
|---|---|---|
| 1973–74 resident charges: | | |
| Average total monthly charge per resident | $489 | $456 |
| Percent of homes by average total monthly charge per resident: | | |
| Less than $299 | 16.2 | 22.4 |
| $300 to $399 | 27.4 | 30.2 |
| $400 to $499 | 26.1 | 22.9 |
| $500 to $599 | 16.5 | 10.0 |
| $600 or more | 13.8 | 14.4 |
| 1972 facility costs: | | |
| Average total costs per resident day | $14.86 | $17.71 |
| Labor costs per resident day | 8.53 | 10.90 |
| Nursing staff costs per resident day | 5.10 | 6.06 |
| Operating, fixed, and miscellaneous costs per resident day | 6.33 | 6.81 |
| Percent of homes by average total cost per resident day: | | |
| Less than $10 | 24.7 | 17.6 |
| $10 to $14.99 | 36.9 | 34.4 |
| $15 to $19.99 | 24.3 | 18.5 |
| $20 or more | 14.1 | 29.5 |
| Percent of homes by average labor costs per resident day: | | |
| Less than $4 | 9.5 | 5.6 |
| $4 to $7.99 | 43.4 | 36.7 |
| $8 to $11.99 | 34.1 | 25.4 |
| $12 or more | 13.0 | 32.3 |
| Percent of homes by average fixed costs per resident day: | | |
| Less than $1 | 13.2 | 39.5 |
| $1 to $1.99 | 33.4 | 29.6 |
| $2 to $2.99 | 24.6 | 15.5 |
| $3 or more | 28.8 | 15.4 |
| Percent of homes by average operating costs per resident day: | | |
| Less than $2 | 21.1 | 16.8 |
| $2 to $2.99 | 43.6 | 27.7 |
| $3 to $3.99 | 18.7 | 19.3 |
| $4 or more | 16.7 | 36.2 |
| Percent of homes by average miscellaneous costs per resident day: | | |
| Less than $0.50 | 53.8 | 60.9 |
| $0.50 to $0.99 | 29.4 | 18.9 |
| $1 to $1.99 | 12.4 | 13.4 |
| $2 or more | 4.5 | 6.8 |

Note: Figures may not add to totals due to rounding.

Source: "Selected Operating and Financial Characteristics of Nursing Homes, United States: 1973–74 National Nursing Home Survey." U.S. Department of Health, Education, and Welfare, Public Health Service. Vital and Health Statistics Series 13, No. 22.

Included in the total numbers of nursing homes are skilled nursing facilities which are homes certified to provide skilled nursing care and related services under the medicare or medicaid programs, and in some cases, both programs. In July 1975, there were 3,932 skilled nursing facilities approved for medicare beneficiaries. These participating institutions accounted for 287,479 beds, or 13.3 beds per 1,000 medicare enrollees. The availability of medicare skilled nursing beds, however, is uneven through the country, ranging from 2.6 beds per 1,000 enrollees in the West South Central States to 33.1 beds per 1,000 enrollees in the Pacific States.

TABLE 11.—*Medicare participating skilled nursing facilities, as of July 1975*

| Division and State | Facilities | Beds [1] | Beds per 1,000 enrollees [2] |
|---|---|---|---|
| All areas | 3, 932 | 287, 479 | 13. 3 |
| United States | 3, 926 | 287, 087 | 13. 4 |
| New England | 304 | 21, 206 | 15. 8 |
| Maine | 17 | 687 | 5. 4 |
| New Hampshire | 20 | 1, 006 | 11. 4 |
| Vermont | 21 | 820 | 15. 6 |
| Massachusetts | 95 | 5, 880 | 9. 0 |
| Rhode Island | 21 | 1, 133 | 10. 3 |
| Connecticut | 130 | 11, 680 | 37. 9 |
| Middle Atlantic | 654 | 67, 508 | 16. 6 |
| New York | 357 | 45, 690 | 22. 9 |
| New Jersey | 125 | 9, 249 | 12. 6 |
| Pennsylvania | 172 | 12, 569 | 9. 4 |
| East North Central | 664 | 42, 362 | 10. 6 |
| Ohio | 183 | 14, 229 | 13. 7 |
| Indiana | 108 | 5, 189 | 10. 0 |
| Illinois | 173 | 7, 919 | 7. 0 |
| Michigan | 144 | 11, 906 | 14. 8 |
| Wisconsin | 56 | 3, 119 | 6. 2 |
| West North Central | 227 | 10, 813 | 5. 4 |
| Minnesota | 83 | 4, 301 | 10. 0 |
| Iowa | 32 | 915 | 2. 5 |
| Missouri | 55 | 2, 855 | 4. 9 |
| North Dakota | 3 | 46 | . 6 |
| South Dakota | 10 | 326 | 3. 9 |
| Nebraska | 15 | 806 | 4. 2 |
| Kansas | 29 | 1, 564 | 5. 6 |
| South Atlantic | 500 | 32, 770 | 10. 1 |
| Delaware | 11 | 632 | 12. 9 |
| Maryland | 67 | 5, 490 | 17. 3 |
| District of Columbia | 5 | 641 | 9. 8 |
| Virginia | 36 | 1, 498 | 3. 8 |
| West Virginia | 28 | 1, 718 | 8. 3 |
| North Carolina | 89 | 6, 086 | 13. 2 |
| South Carolina | 71 | 4, 738 | 12. 0 |
| Georgia | 47 | 2, 787 | 7. 0 |
| Florida | 146 | 9, 185 | 8. 1 |
| East South Central | 230 | 12, 799 | 9. 3 |
| Kentucky | 84 | 5, 289 | 14. 8 |
| Tennessee | 38 | 1, 383 | 3. 3 |
| Alabama | 89 | 5, 372 | 15. 1 |
| Mississippi | 19 | 755 | 3. 1 |
| West South Central | 76 | 5, 158 | 2. 6 |
| Arkansas | 10 | 557 | 2. 2 |
| Louisiana | 11 | 1, 127 | 3. 4 |
| Oklahoma | 7 | 434 | 1. 4 |
| Texas | 48 | 3, 040 | 2. 8 |
| Mountain | 177 | 8, 741 | 11. 0 |
| Montana | 26 | 870 | 11. 9 |
| Idaho | 28 | 1, 588 | 20. 8 |
| Wyoming | 2 | 128 | 3. 9 |
| Colorado | 62 | 3, 772 | 18. 7 |
| New Mexico | 7 | 323 | 3. 8 |
| Arizona | 19 | 1, 000 | 5. 1 |
| Utah | 14 | 431 | 5. 0 |
| Nevada | 19 | 629 | 15. 9 |
| Pacific | 1, 094 | 85, 730 | 33. 1 |
| Washington | 90 | 3, 106 | 8. 9 |
| Oregon | 51 | 2, 150 | 8. 7 |
| California | 933 | 78, 895 | 40. 8 |
| Alaska | 4 | 166 | 21. 5 |
| Hawaii | 16 | 1, 413 | 27. 1 |

Footnotes at end of table.

TABLE 11.—*Medicare participating skilled nursing facilities, as of July 1975*—Continued

| Division and State | Facilities | Beds [1] | Beds per 1,000 enrollees [2] |
|---|---|---|---|
| Outlying areas | 6 | 392 | 1. 9 |
| Guam | 1 | 33 | 21. 8 |
| Puerto Rico | 5 | 359 | 1. 8 |
| Virgin Islands | | | |
| American Samoa | | | |

[1] Includes skilled nursing beds only.

[2] Based on number of enrollees in hospital insurance program as of Jan. 1, 1974, reflected in SSA records as of Oct. 1, 1973.

Source: Social Security Administration, Office of Research and Statistics, Health Insurance Studies Division.

In November 1975, some 7,100 skilled nursing facilities with about 537,000 certified beds were providing services under State-administered medical assistance (medicaid) programs. During that period, about 8,600 intermediate care facilities with more than 493,000 certified beds were also providing care to medicaid recipients.[1] California, by far, had the greatest number of skilled nursing facilities and certified skilled nursing beds (25.2 percent and 21.7 percent, respectively); while, Texas had the largest number of intermediate care facilities and certified intermediate care beds (9.2 percent and 12.7 percent, respectively).

---

[1] It should be cautioned that a certain percentage of beds certified as intermediate care facility at the same time, may be certified as skilled nursing facility beds due to current State medicaid policies known as the "swing bed" concept. Under these policies, a State may define a certified bed as an intermediate care or skilled nursing care bed based on the medical diagnosis of the patient currently occupying that bed.

TABLE 12.—*Survey of skilled nursing homes and intermediate care facilities, as of November 1975*

| Regions | Skilled nursing facilities certified under medicare and medicaid | | Skilled nursing facilities certified under medicaid only | | Intermediate care facilities certified under medicaid | | Intermediate care facilities for the mentally retarded certified under medicaid | |
|---|---|---|---|---|---|---|---|---|
| | Number of facilities | Number of certified beds | Number of facilities | Number of certified beds | Number of facilities | Number of certified beds | Number of facilities | Number of certified beds |
| All regions | 3, 960 | 301, 061 | 3, 151 | 236, 044 | 8, 406 | 462, 031 | 228 | 31, 206 |
| Region I, total | 307 | 21, 737 | 239 | 12, 241 | 1, 053 | 44, 209 | 13 | 2, 497 |
| Connecticut | 131 | 11, 834 | 74 | 4, 222 | 57 | 2, 676 | 0 | 0 |
| Maine | 18 | 707 | 1 | 21 | 128 | 6, 103 | 1 | 198 |
| Massachusetts | 96 | 6, 263 | 144 | 7, 178 | 641 | 28, 450 | 0 | 0 |
| New Hampshire | 20 | 980 | 0 | 0 | 52 | 3, 763 | 0 | 0 |
| Rhode Island | 21 | 1, 133 | 19 | 797 | 125 | 3, 227 | 12 | 143 |
| Vermont | 21 | 820 | 1 | 20 | 50 | 0 | 0 | 2, 156 |
| Region II, total | 486 | 55, 993 | 306 | 25, 340 | 286 | 51, 462 | 0 | 0 |
| New Jersey | 123 | 9, 250 | 95 | 8, 324 | 102 | 8, 997 | 0 | 0 |
| New York | 358 | 46, 384 | 211 | 17, 016 | 184 | 42, 465 | 0 | 0 |
| Puerto Rico | 5 | 359 | 0 | 0 | 0 | 0 | 0 | 0 |
| Virgin Islands | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Region III, total | 319 | 22, 422 | 277 | 24, 490 | 524 | 34, 113 | 0 | 0 |
| Delaware | 11 | 730 | 3 | 615 | 19 | 468 | 0 | 0 |
| District of Columbia | 5 | 641 | 0 | 0 | 6 | 943 | 0 | 0 |
| Maryland | 67 | 5, 525 | 32 | 2, 591 | 107 | 5, 628 | 0 | 0 |
| Pennsylvania | 172 | 12, 288 | 240 | 20, 976 | 201 | 17, 118 | 0 | 0 |
| Virginia | 36 | 1, 493 | 2 | 308 | 128 | 7, 831 | 0 | 0 |
| West Virginia | 28 | 1, 745 | 0 | 0 | 63 | 2, 125 | 0 | 0 |
| Region IV, total | 587 | 35, 094 | 488 | 39, 506 | 785 | 47, 362 | 22 | 4, 905 |
| Alabama | 89 | 5, 185 | 77 | 4, 448 | 140 | 5, 178 | 0 | 0 |
| Florida | 146 | 8, 892 | 109 | 10, 372 | 29 | 871 | 0 | 0 |
| Georgia | 47 | 2, 859 | 190 | 17, 456 | 189 | 15, 497 | 7 | 1, 175 |
| Kentucky | 85 | 5, 289 | 0 | 0 | 82 | 3, 874 | 7 | 844 |
| Mississippi | 19 | 691 | 75 | 5, 546 | 25 | 715 | 0 | 0 |
| North Carolina | 91 | 6, 134 | 24 | 1, 142 | 66 | 4, 390 | 4 | 2, 630 |
| South Carolina | 72 | 4, 661 | 8 | 368 | 52 | 2, 248 | 4 | 256 |
| Tennessee | 38 | 1, 383 | 5 | 174 | 202 | 14, 589 | 0 | 0 |
| Region V, total | 759 | 48, 102 | 731 | 46, 768 | 2, 288 | 55, 372 | 128 | 6, 969 |
| Illinois | 175 | 8, 577 | 108 | 5, 942 | 85 | 2, 023 | 0 | 0 |
| Indiana | 108 | 5, 284 | 13 | 853 | 390 | 10, 209 | 0 | 0 |
| Michigan | 146 | 12, 012 | 258 | 18, 526 | 268 | 3, 944 | 8 | 625 |
| Minnesota | 84 | 4, 428 | 179 | 3, 724 | 402 | 6, 640 | 100 | 2, 477 |
| Ohio | 187 | 14, 608 | 150 | 6, 150 | 598 | 6, 384 | 3 | 27 |
| Wisconsin | 59 | 3, 193 | 23 | 11, 573 | 545 | 26, 172 | 17 | 3, 840 |

TABLE 12.—*Survey of skilled nursing homes and intermediate care facilities, as of November 1975*—Continued

| Regions | Skilled nursing facilities certified under medicare and medicaid |  | Skilled nursing facilities certified under medicaid only |  | Intermediate care facilities certified under medicaid |  | Intermediate care facilities for the mentally retarded certified under medicaid |  |
|---|---|---|---|---|---|---|---|---|
|  | Number of facilities | Number of certified beds | Number of facilities | Number of certified beds | Number of facilities | Number of certified beds | Number of facilities | Number of certified beds |
| Region VI, total | 84 | 5, 497 | 295 | 20, 789 | 1, 531 | 118, 142 | 29 | 11, 372 |
| Arkansas | 10 | 557 | 65 | 6, 011 | 165 | 13, 551 | 4 | 1, 573 |
| Louisiana | 11 | 1, 127 | 2 | 165 | 194 | 17, 162 | 9 | 3, 837 |
| New Mexico | 7 | 323 | 1 | 30 | 32 | 2, 013 | 1 | 138 |
| Oklahoma | 7 | 434 | 3 | 296 | 342 | 24, 611 | 15 | 4, 061 |
| Texas | 49 | 3, 056 | 224 | 14, 287 | 798 | 60, 805 | 0 | 1, 763 |
| Region VII, total | 132 | 6, 366 | 104 | 7, 761 | 1, 188 | 67, 320 | 1 | 14 |
| Iowa | 32 | 915 | 0 | 0 | 522 | 25, 004 | 0 | 0 |
| Kansas | 29 | 1, 680 | 35 | 2, 080 | 334 | 17, 191 | 1 | 14 |
| Missouri | 56 | 2, 915 | 48 | 3, 978 | 122 | 11, 043 | 0 | 0 |
| Nebraska | 15 | 856 | 21 | 1, 703 | 200 | 14, 082 | 0 | 0 |
| Region VIII, total | 118 | 5, 620 | 259 | 15, 867 | 414 | 16, 224 | 26 | 2, 201 |
| Colorado | 63 | 3, 819 | 86 | 5, 979 | 167 | 5, 432 | 17 | 1, 723 |
| Montana | 26 | 870 | 48 | 1, 811 | 43 | 2, 386 | 6 | 402 |
| North Dakota | 3 | 46 | 48 | 3, 423 | 25 | 1, 471 | 0 | 0 |
| South Dakota | 10 | 326 | 46 | 2, 868 | 63 | 2, 968 | 2 | 76 |
| Utah | 14 | 431 | 23 | 1, 221 | 104 | 3, 234 | 1 | 0 |
| Wyoming | 2 | 128 | 8 | 565 | 12 | 733 | 0 | 0 |
| Region IX, total | 993 | 93, 071 | 255 | 27, 012 | 140 | 8, 764 | 1 | 11 |
| American Samoa | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Arizona | 19 | 1, 000 | 0 | 0 | 0 | 0 | 0 | 0 |
| California | 938 | 90, 021 | 255 | 26, 492 | 129 | 8, 764 | 0 | 0 |
| Guam | 1 | 33 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hawaii | 16 | 1, 413 | 0 | 520 | 11 | 0 | 1 | 11 |
| Nevada | 19 | 604 | 0 | 0 | 0 | 0 | 0 | 0 |
| Region X, total | 175 | 7, 159 | 197 | 16, 270 | 197 | 19, 063 | 8 | 3, 237 |
| Alaska | 4 | 166 | 6 | 164 | 10 | 467 | 2 | 174 |
| Idaho | 28 | 1, 668 | 23 | 1, 538 | 57 | 4, 710 | 2 | 617 |
| Oregon | 52 | 2, 173 | 7 | 431 | 153 | 9, 295 | 4 | 2, 446 |
| Washington | 91 | 3, 152 | 161 | 14, 147 | 77 | 4, 391 | 0 | 0 |

Source: Social Security Administration, Office of Research and Statistics, Health Insurance Studies Division.

## EXPENDITURES FOR NURSING HOME CARE

During fiscal year 1975, nursing home care expenditures in the United States reached $9.0 billion or 7.6 percent of total expenditures for health services and supplies. Nearly 58 percent of all nursing home care is financed from public funds, particularly the medicaid program. The Federal Government provides 57.3 percent of all public moneys used to purchase nursing home care.

TABLE 13.—*Expenditures for nursing home care, fiscal year 1975*

| | |
|---|---|
| Total | $9, 000, 300, 000 |
| Private sources, total | 3, 799, 000, 000 |
| Consumers | 3, 767, 000, 000 |
| Other | 32, 000, 000 |
| Public sources, total | 5, 201, 300, 000 |
| Public assistance payments, total | 4, 782, 400, 000 |
| Federal | 2, 562, 900, 000 |
| State and local | 2, 219, 500, 000 |
| Medicare | 257, 000, 000 |
| Veterans' Administration | 161, 900, 000 |

Source: "National Health Expenditures." Social Security Bulletin; February 1976.

TABLE 14.—*Expenditures for nursing home care, fiscal years 1950–75*

[In millions]

| | Total expenditures | Source of funds | | Public expenditures as percent of total expenditures |
|---|---|---|---|---|
| | | Private | Public | |
| 1950 | $178 | $167 | $11 | 6. 2 |
| 1960 | 480 | 353 | 127 | 26. 5 |
| 1965 | 1, 271 | 822 | 449 | 35. 3 |
| 1966 | 1, 407 | (1) | (1) | (1) |
| 1967 | 1, 751 | 844 | 907 | 51. 8 |
| 1968 | 2, 360 | 894 | 1, 466 | 62. 1 |
| 1969 | 3, 057 | 1, 354 | 1, 703 | 55. 7 |
| 1970 | 3, 818 | 2, 145 | 1, 673 | 43. 8 |
| 1971 | 4, 890 | 2, 919 | 1, 971 | 40. 3 |
| 1972 | 5, 860 | 3, 395 | 2, 465 | 42. 1 |
| 1973 | 6, 650 | 3, 477 | 3, 173 | 47. 7 |
| 1974 | 7, 450 | 3, 574 | 3, 876 | 52. 0 |
| 1975 | 9, 000 | 3, 799 | 5, 201 | 57. 8 |

[1] Not available.

Source: "National Health Expenditures." Social Security Bulletin; February 1975 and February 1976.

## Home Health Care

The term "home health care" is generally used to describe therapeutic and preventive health services provided to patients in their place of residence because of acute or chronic illness or disability. The Department of Health, Education, and Welfare describes the varying levels of home health care in this way:

> Home health services are provided singly or in combinations of varying intensity that are defined as "levels" of care as follows: (1) concentrated or intensive services for those individuals who otherwise would need to be hospitalized but who can benefit from multiple professional, diagnostic, therapeutic, and supportive services under professional supervision and coordination on an intermittent basis; (2) intermediate services—a less concentrated array of home health services for individuals who need convalescent care from acute illness or have a temporary disability related to chronic illness; and (3) basic services—a simple combination of health supervision and maintenance designed to maintain individuals who have long-term care needs in their own homes, thus preventing or postponing the need of institutionalization.[1]

Both medicare and medicaid pay for home health services. Medicare provides up to 200 home health visits to a beneficiary who has been certified by a physician as requiring part-time skilled nursing care or physical or speech therapy. A maximum of 100 home health visits is authorized under the Hospital Insurance Program (part A) as a posthospital benefit during the 12 months following hospitalization; and a maximum of 100 visits is provided under the Supplementary Medical Insurance Program (part B) without prior hospitalization during any calendar year. Medicare pays the full cost of a home health visit under part A and the full cost under part B after the patient has satisfied a $60 yearly deductible for all part B services.

Home health services are defined by the medicare statute as part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services, medical supplies and equipment; and, to the extent permitted by regulation, home health aide services.

Coverage of home health services is a mandatory requirement under the medicaid program for all medicaid recipients who are eligible to receive skilled nursing facility services. Unlike medicare, medicaid places no restrictions on the number of visits provided to a recipient if he is eligible to receive them. However, as with all services provided under medicaid, a State may place limits on the amount and scope of any service offered under its medical assistance program.

The medicaid statute does not define the term "home health services." However, regulations permit the inclusion of any of the following services in a State's home health care plan when provided on the recommendation of a licensed physician to a patient in his place of residence:

> (1) Intermittent or part-time nursing services furnished by a home health agency;

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[1] Department of Health, Education, and Welfare. Public Health Service. "Health Resources Statistics, 1974".

(2) Intermittent or part-time nursing services furnished by a registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency is available;

(3) Medical supplies, equipment, and appliances authorized by the physician;

(4) Services of a home health aide, assigned to give personal care services to a patient in accordance with the physician's plan of treatment, and supervised by the home health agency.

### HOME HEALTH AGENCIES

Medicare statute defines a home health agency as a public or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Proprietary organizations are permitted to participate in the program if they are licensed by State law. Currently, fourteen States license home health agencies. In addition to the statutory language, medicare regulations specify that the agency must provide part-time or intermittent skilled nursing services and at least one other therapeutic service, on a visiting basis, in the patient's place of residence. A public or nonprofit private agency must provide one service directly through its own employees, but is permitted to contract for the provision of additional services. Proprietary agencies must provide all services directly.

Although the medicaid statute does not define a home health agency, medicaid regulations define it as a public or private organization which is qualified to participate as a home health agency under medicare, or is determined currently to meet the requirements for medicare participation.

In fiscal year 1975, medicare expenditures for home health care totaled $183 million ($132 million under Part A and $51 million under Part B). In fiscal year 1974 (latest available data), medicaid expenditures for home health care equaled $31 million. In both years, home health care accounted for less than 1 percent of total expenditures under each program.

The following tables provide data on home health agencies participating in the medicare and medicaid programs. No reliable data exists on the total number of organizations, nationwide, which are capable of providing health services in the home.

TABLE 15.—*Medicare participating home health agencies, by region and State, December 1975*

| *Region and State* | *Home health agencies* |
|---|---|
| All regions | 2, 185 |
| Boston region | 333 |
| Connecticut | 86 |
| Maine | 19 |
| Massachusetts | 159 |
| New Hampshire | 40 |
| Rhode Island | 13 |
| Vermont | 16 |
| New York region | 181 |
| New Jersey | 44 |
| New York | 123 |
| Puerto Rico | 13 |
| Virgin Islands | 1 |

TABLE 15.—*Medicare participating home health agencies, by region and State, December 1975*—Continued

| *Region and State* | *Home Health agencies* |
|---|---|
| Philadelphia region | 198 |
| Delaware | 6 |
| District of Columbia | 3 |
| Maryland | 26 |
| Pennsylvania | 102 |
| Virginia | 43 |
| West Virginia | 18 |
| Atlanta region | 430 |
| Alabama | 66 |
| Florida | 43 |
| Georgia | 17 |
| Kentucky | 42 |
| Mississippi | 89 |
| North Carolina | 61 |
| South Carolina | 15 |
| Tennessee | 97 |
| Chicago region | 389 |
| Illinois | 81 |
| Indiana | 30 |
| Michigan | 48 |
| Minnesota | 62 |
| Ohio | 100 |
| Wisconsin | 68 |
| Dallas region | 260 |
| Arkansas | 79 |
| Louisiana | 74 |
| New Mexico | 7 |
| Oklahoma | 51 |
| Texas | 49 |
| Kansas City region | 145 |
| Iowa | 64 |
| Kansas | 34 |
| Missouri | 35 |
| Nebraska | 12 |
| Denver region | 84 |
| Colorado | 28 |
| Montana | 10 |
| North Dakota | 9 |
| South Dakota | 21 |
| Utah | 8 |
| Wyoming | 8 |
| San Francisco region | 106 |
| American Samoa | -- |
| Arizona | 10 |
| California | 88 |
| Guam | 1 |
| Hawaii | 4 |
| Nevada | 3 |
| Seattle region | 59 |
| Alaska | 1 |
| Idaho | 9 |
| Oregon | 25 |
| Washington | 24 |

Source: Social Security Administration, Office of Research and Statistics, Health Insurance Studies; Participating Health Facilities Under Medicare, December 1975.

TABLE 16.—*Medicaid participating home health agencies, by State, November 1975* [1]

| *State* | *Home health agencies* |
|---|---|
| Totals [2] | 1,934 |
| Alabama | 68 |
| Alaska | 1 |
| Arizona | (3) |
| Arkansas | 6 |
| California | 73 |
| Colorado | (4) |
| Connecticut | 129 |
| Delaware | 8 |
| District of Columbia | 2 |
| Florida | 53 |
| Georgia | 14 |
| Guam | [5] 0 |
| Hawaii | 3 |
| Idaho | 9 |
| Illinois | 80 |
| Indiana | 30 |
| Iowa | 32 |
| Kansas | 20 |
| Kentucky | 37 |
| Louisiana | 82 |
| Maine | (4) |
| Maryland | [6] 29 |
| Massachusetts | (4) |
| Michigan | 47 |
| Minnesota | 65 |
| Mississippi | 92 |
| Missouri | 31 |
| Montana | 18 |
| Nebraska | 15 |
| Nevada | 3 |
| New Hampshire | 40 |
| New Jersey | 44 |
| New Mexico | 7 |
| New York | 129 |
| North Carolina | 63 |
| North Dakota | 8 |
| Ohio | 125 |
| Oklahoma | 2 |
| Oregon | 20 |
| Pennsylvania | 104 |
| Puerto Rico | 4 |
| Rhode Island | 9 |
| South Carolina | 51 |
| South Dakota | (4) |
| Tennessee | 96 |
| Texas | 41 |
| Utah | 8 |
| Vermont | (4) |
| Virgin Islands | 1 |
| Virginia | 136 |
| Washington | (4) |
| West Virginia | 18 |
| Wisconsin | 69 |
| Wyoming | 12 |

[1] All figures have been supplied by the States.
[2] Totals based on incomplete data. Not all States reported as requested.
[3] Program not implemented.
[4] State did not report.
[5] Government provider through Public Health.
[6] Includes out-of-State certified providers to whom payments and services are being made.

Source: U.S. Department of Health, Education, and Welfare, Medical Services Administration.

# Chapter 2. Health Manpower

## INTRODUCTION

The health industry employes about 4.7 million professional and nonprofessional workers. There are, of course, as indicated in chart 1a of chapter 1 in part I, many different kinds of workers in the health care field. This chapter deals with almost all of the health professions whose members deal directly with patients in providing health care services.

The educational data for physicians is more comprehensive than that for other professions, first because the field is complex, and second because the supply and distribution of physicians is a key element in developing health policy.

## I. Physician Manpower [1]

### A. NUMBERS, SPECIALTIES, AND GEOGRAPHIC DISTRIBUTION OF DOCTORS OF MEDICINE

There were 330,266 professionally active physicians [2] in the United States and its possessions as of December 31, 1974. In addition, 21,614 physicians were considered inactive; the activity status of 20,343 was uncertain; and 7,525 could not be located.

Of the active physicians in the United States, the vast majority (91.2 percent) were engaged in patient care activities. The remaining were involved in medical teaching, administration, research, or other activities.

Of the total number of physicians engaged in patient care activities, 52,932 (17.5 percent) were in general practice; 80,526 (26.7 percent) were in medical specialties; and 89,821 (29.8 percent) were in surgical specialties. Table 1 presents this data in more detail.

TABLE 1.—*Federal and non-Federal physicians by activity and specialty group, Dec. 31, 1974*

| *Activity: Specialty group* | *Total [1] (100 percent)* |
|---|---|
| Total physicians | 330, 266 |
| Total patient care | 301, 238 |
| General practice | 52, 932 |
| Medical specialities | 80, 526 |
| Surgical specialities | 89, 821 |
| Other specialities | 77, 959 |
| Medical teaching | 6, 464 |
| Administration | 11, 739 |
| Research | 8, 159 |
| Other | 2, 666 |

[1] Excludes 21,614 inactive, 20,343 not classified, and 7,525 address unknown.

Source: "Physician Distribution and Medical Licensure in the U.S., 1974" Center for Health Services Research and Development, AMA, 1975.

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[1] Unless otherwise noted all data presented in this section on physician manpower are provided by the American Medical Association's Center for Health Services Research and Development in "Distribution of Physicians in the United States, 1972," vol. 1.

[2] Information on doctors of osteopathy (D.O.) is presented later in this chapter. See p. 128.

TABLE 2.—*Non-Federal physicians in United States and possessions, by specialty and activity, Dec. 31, 1974*

| Specialty | Total physicians | Major professional activity | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Patient care | | | | | | | |
| | | | | Hospital based practice | | | | | | |
| | | Total | Office based practice | Interns | Residents | Full-time physicians staff | Medical teaching | Administration | Research | Other |
| Total physicians | 345, 607 | 278, 517 | 203, 943 | 10, 777 | 43, 733 | 20, 064 | 5, 863 | 9, 918 | 7, 051 | 2, 301 |
| General practice | 51, 861 | 50, 935 | 46, 808 | -------- | 2, 280 | 1, 847 | 144 | 507 | 89 | 186 |
| Medical specialties | 81, 411 | 73, 289 | 49, 795 | 4, 131 | 14, 493 | 4, 870 | 2, 187 | 2, 378 | 3, 173 | 384 |
| Allergy | 1, 571 | 1, 452 | 1, 423 | -------- | -------- | 29 | 22 | 19 | 75 | 3 |
| Cardiovascular diseases | 5, 758 | 4, 900 | 4, 404 | -------- | -------- | 496 | 260 | 194 | 358 | 46 |
| Dermatology | 4, 090 | 3, 868 | 3, 288 | -------- | 510 | 70 | 76 | 42 | 90 | 14 |
| Gastroenterology | 1, 819 | 1, 495 | 1, 392 | -------- | -------- | 103 | 108 | 45 | 165 | 6 |
| Internal medicine | 46, 158 | 41, 874 | 25, 993 | 3, 243 | 10, 174 | 2, 464 | 956 | 1, 298 | 1, 821 | 209 |
| Pediatrics | 19, 302 | 17, 577 | 11, 827 | 888 | 3, 674 | 1, 188 | 558 | 625 | 450 | 92 |
| Pediatric allergy | 412 | 371 | 296 | -------- | 55 | 20 | 13 | 6 | 22 | -------- |
| Pediatric cardiology | 516 | 386 | 215 | -------- | 80 | 91 | 63 | 18 | 46 | 3 |
| Pulmonary diseases | 1, 785 | 1, 366 | 957 | -------- | -------- | 409 | 131 | 131 | 146 | 11 |
| Surgical specialties | 87, 322 | 84, 282 | 64, 987 | 1, 705 | 14, 772 | 2, 818 | 1, 044 | 939 | 826 | 231 |
| General surgery | 28, 902 | 27, 906 | 19, 325 | 1, 351 | 6, 024 | 1, 206 | 289 | 383 | 245 | 79 |
| Neurological surgery | 2, 688 | 2, 559 | 1, 893 | -------- | 542 | 124 | 51 | 21 | 45 | 12 |
| Obstetrics and gynecology | 19, 892 | 19, 008 | 15, 116 | 354 | 2, 915 | 623 | 287 | 317 | 232 | 48 |
| Ophthalmology | 10, 211 | 9, 901 | 8, 450 | -------- | 1, 280 | 171 | 99 | 57 | 136 | 18 |
| Orthopedic surgery | 10, 102 | 9, 850 | 7, 759 | -------- | 1, 839 | 252 | 121 | 48 | 50 | 33 |
| Otolaryngology | 5, 122 | 4, 961 | 4, 146 | -------- | 715 | 100 | 63 | 34 | 47 | 17 |
| Plastic surgery | 1, 977 | 1, 914 | 1, 566 | -------- | 299 | 49 | 31 | 12 | 13 | 7 |
| Colon and rectal surgery | 649 | 637 | 607 | -------- | 20 | 10 | 1 | 5 | 4 | 2 |
| Thoracic surgery | 1, 759 | 1, 668 | 1, 316 | -------- | 241 | 111 | 36 | 26 | 26 | 3 |
| Urology | 6, 020 | 5, 878 | 4, 809 | -------- | 897 | 172 | 66 | 36 | 28 | 12 |
| Other specialties | 83, 056 | 70, 011 | 42, 353 | 4, 941 | 12, 188 | 10, 529 | 2, 488 | 6, 094 | 2, 963 | 1, 500 |
| Aerospace medicine | 182 | 123 | 91 | -------- | 23 | 9 | 6 | 23 | 17 | 13 |
| Anesthesiology | 11, 782 | 11, 080 | 8, 460 | -------- | 1, 681 | 939 | 434 | 150 | 91 | 27 |
| Child psychiatry | 2, 303 | 1, 899 | 1, 337 | -------- | 278 | 284 | 132 | 199 | 45 | 28 |
| Diagnostic radiology | 2, 728 | 2, 526 | 1, 675 | -------- | 499 | 352 | 95 | 31 | 16 | 60 |
| Forensic pathology | 184 | 95 | 76 | -------- | 7 | 12 | 9 | 30 | 5 | 45 |
| Neurology | 3, 334 | 2, 766 | 1, 695 | -------- | 831 | 240 | 180 | 71 | 296 | 21 |
| Occupational medicine | 2, 138 | 1, 554 | 1, 506 | -------- | 3 | 45 | 3 | 478 | 25 | 78 |
| Psychiatry | 21, 073 | 18, 508 | 11, 731 | -------- | 3, 484 | 3, 293 | 438 | 1, 619 | 392 | 116 |
| Pathology | 10, 215 | 8, 255 | 3, 834 | 145 | 2, 180 | 2, 096 | 426 | 454 | 543 | 537 |
| Physical medicine and rehabilitation | 1, 332 | 1, 208 | 586 | -------- | 256 | 366 | 22 | 72 | 14 | 16 |
| General preventive medicine | 591 | 242 | 200 | -------- | 25 | 17 | 43 | 228 | 58 | 20 |
| Public health | 2, 237 | 568 | 481 | -------- | 37 | 50 | 91 | 1, 391 | 81 | 106 |
| Radiology | 10, 588 | 9, 934 | 6, 713 | -------- | 1, 777 | 1, 444 | 219 | 123 | 98 | 214 |
| Therapeutic radiology | 988 | 945 | 575 | -------- | 206 | 164 | 23 | 7 | 13 | -------- |
| Other specialty | 5, 845 | 3, 104 | 2, 150 | -------- | -------- | 954 | 333 | 1, 052 | 1, 190 | 166 |
| Unspecified | 7, 536 | 7, 204 | 1, 243 | 4, 796 | 901 | 264 | 34 | 166 | 79 | 53 |
| Not classified | 20, 343 | -------- | -------- | -------- | -------- | -------- | -------- | -------- | -------- | -------- |
| Inactive | 21, 614 | -------- | -------- | -------- | -------- | -------- | -------- | -------- | -------- | -------- |

Source: "Physician Distribution and Medical Licensure in the U.S., 1974," Center for Health Services Research and Development, AMA, 1975.

The distribution of active non-Federal physicians by region is outlined in table 3. The northeast census region (New England and Middle Atlantic States) has the largest number of active non-Federal physicians. This region has the largest percentage of physicians in patient care activities, administration, and research. Almost 40 percent of all physicians engaged in research are located in this census region.

TABLE 3.—*Non-Federal physicians by census region division, and activity, Dec. 31, 1974*

| Census Region Division | Total physicians [1] | | Patient care | | Medical teaching | | Administration | | Research | | Other | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Total, Non-Federal | 303, 650 | 100. 0 | 278, 517 | 100. 0 | 5, 863 | 100. 0 | 9, 918 | 100. 0 | 7, 051 | 100. 0 | 2, 301 | 100. 0 |
| Northeast | 89, 969 | 29. 6 | 81, 327 | 29. 2 | 1, 656 | 28. 2 | 3, 468 | 35. 0 | 2, 800 | 39. 7 | 718 | 31. 2 |
| New England | 22, 006 | 7. 2 | 19, 703 | 7. 1 | 372 | 6. 3 | 847 | 8. 5 | 907 | 12. 9 | 177 | 7. 7 |
| Middle Atlantic | 67, 963 | 22. 4 | 61, 624 | 22. 1 | 1, 284 | 21. 9 | 2, 621 | 26. 4 | 1, 893 | 26. 8 | 541 | 23. 5 |
| North Central | 71, 241 | 23. 5 | 65, 990 | 23. 7 | 1, 394 | 23. 8 | 1, 992 | 20. 1 | 1, 351 | 19. 2 | 514 | 22. 3 |
| East North Central | 51, 211 | 16. 9 | 47, 561 | 17. 1 | 932 | 15. 9 | 1, 457 | 14. 7 | 880 | 12. 5 | 381 | 16. 6 |
| West North Central | 20, 030 | 6. 6 | 18, 429 | 6. 6 | 462 | 7. 9 | 535 | 5. 4 | 471 | 6. 7 | 133 | 5. 8 |
| South | 79, 525 | 26. 2 | 73, 328 | 26. 3 | 1, 681 | 28. 7 | 2, 405 | 24. 2 | 1, 555 | 22. 1 | 556 | 24. 2 |
| South Atlantic | 43, 539 | 14. 3 | 39, 872 | 14. 3 | 919 | 15. 7 | 1, 501 | 15. 1 | 923 | 13. 1 | 324 | 14. 1 |
| East South Central | 13, 471 | 4. 4 | 12, 509 | 4. 5 | 270 | 4. 6 | 359 | 3. 6 | 244 | 3. 5 | 89 | 3. 9 |
| West South Central | 22, 515 | 7. 4 | 20, 947 | 7. 5 | 492 | 8. 4 | 545 | 5. 5 | 388 | 5. 5 | 143 | 6. 2 |
| West | 60, 262 | 19. 8 | 55, 425 | 19. 9 | 1, 068 | 18. 2 | 1, 948 | 19. 6 | 1, 317 | 18. 7 | 504 | 21. 9 |
| Mountain | 12, 272 | 4. 0 | 11, 396 | 4. 1 | 203 | 3. 5 | 359 | 3. 6 | 216 | 3. 1 | 98 | 4. 3 |
| Pacific | 47, 990 | 15. 8 | 44, 029 | 15. 8 | 865 | 14. 8 | 1, 589 | 16. 0 | 1, 101 | 15. 6 | 406 | 17. 6 |
| Possessions | 2, 653 | . 9 | 2, 447 | . 9 | 64 | 1. 1 | 105 | 1. 1 | 28 | . 4 | 9 | . 4 |

[1] Excludes 21,614 inactive, 20,343 not classified, and 7,525 address unknown.

NOTE.—Percentages may not add due to rounding.

TABLE 4.—*Distribution of non-Federal physicians, by State and major professional activity, Dec. 31, 1974*

| State | Total physicians | Patient care | Medical teaching | Administration | Research | Other | Not classified | Inactive |
|---|---|---|---|---|---|---|---|---|
| Alabama | 3, 509 | 2, 967 | 49 | 71 | 75 | 22 | 149 | 176 |
| Alaska | 302 | 245 | 5 | 12 | 4 | 1 | 21 | 14 |
| Arizona | 3, 772 | 2, 876 | 59 | 92 | 34 | 21 | 178 | 512 |
| Arkansas | 2, 039 | 1, 699 | 34 | 40 | 20 | 16 | 83 | 147 |
| California | 44, 093 | 35, 001 | 677 | 1, 266 | 885 | 348 | 2, 349 | 3, 567 |
| Canal Zone | 43 | 36 |  | 2 |  |  | 4 | 1 |
| Colorado | 4, 488 | 3, 645 | 71 | 134 | 110 | 31 | 224 | 273 |
| Connecticut | 6, 646 | 5, 282 | 105 | 272 | 189 | 46 | 336 | 416 |
| Delaware | 850 | 709 | 8 | 31 | 7 | 1 | 38 | 56 |
| District of Columbia | 3, 249 | 2, 408 | 106 | 157 | 76 | 24 | 332 | 146 |
| Florida | 14, 275 | 10, 368 | 185 | 266 | 162 | 97 | 711 | 2, 486 |
| Georgia | 5, 916 | 4, 928 | 112 | 158 | 62 | 31 | 361 | 264 |
| Hawaii | 1, 412 | 1, 131 | 30 | 56 | 17 | 8 | 68 | 102 |
| Idaho | 802 | 683 | 5 | 10 | 4 | 7 | 29 | 64 |
| Illinois | 17, 594 | 14, 409 | 285 | 506 | 324 | 134 | 1, 177 | 759 |
| Indiana | 5, 919 | 4, 962 | 92 | 149 | 81 | 35 | 267 | 333 |
| Iowa | 3, 122 | 2, 614 | 71 | 59 | 50 | 20 | 128 | 180 |
| Kansas | 2, 969 | 2, 441 | 52 | 73 | 40 | 19 | 173 | 171 |
| Kentucky | 3, 879 | 3, 253 | 89 | 96 | 48 | 25 | 187 | 181 |
| Louisiana | 4, 806 | 4, 007 | 120 | 95 | 68 | 31 | 275 | 210 |
| Maine | 1, 342 | 1, 071 | 15 | 39 | 17 | 7 | 52 | 141 |
| Maryland | 8, 567 | 6, 517 | 178 | 331 | 300 | 52 | 752 | 437 |
| Massachusetts | 13, 226 | 10, 228 | 204 | 430 | 610 | 91 | 983 | 680 |
| Michigan | 12, 608 | 10, 184 | 214 | 354 | 179 | 75 | 981 | 621 |
| Minnesota | 6, 522 | 5, 294 | 132 | 137 | 166 | 38 | 399 | 356 |
| Mississippi | 2, 112 | 1, 818 | 19 | 30 | 20 | 12 | 108 | 105 |
| Missouri | 6, 741 | 5, 433 | 132 | 195 | 188 | 46 | 414 | 333 |
| Montana | 814 | 719 | 2 | 10 | 4 | 6 | 26 | 47 |
| Nebraska | 1, 971 | 1, 613 | 67 | 53 | 22 | 7 | 78 | 131 |
| Nevada | 695 | 587 | 7 | 16 | 3 | 4 | 26 | 52 |
| New Hampshire | 1, 247 | 1, 014 | 15 | 35 | 30 | 10 | 31 | 112 |
| New Jersey | 12, 102 | 9, 884 | 126 | 405 | 208 | 89 | 736 | 654 |
| New Mexico | 1, 401 | 1, 090 | 21 | 42 | 22 | 17 | 88 | 121 |
| New York | 45, 026 | 35, 874 | 811 | 1, 634 | 1, 276 | 308 | 2, 927 | 2, 196 |
| North Carolina | 6, 614 | 5, 286 | 126 | 220 | 176 | 40 | 392 | 374 |
| North Dakota | 632 | 538 | 6 | 14 | 5 | 2 | 35 | 32 |
| Ohio | 15, 383 | 12, 938 | 244 | 323 | 205 | 84 | 839 | 750 |
| Oklahoma | 2, 892 | 2, 430 | 51 | 66 | 29 | 17 | 135 | 164 |
| Oregon | 3, 736 | 3, 038 | 67 | 94 | 47 | 27 | 185 | 278 |
| Pennsylvania | 19, 349 | 15, 866 | 347 | 582 | 409 | 144 | 999 | 1, 002 |
| Puerto Rico | 2, 826 | 2, 298 | 64 | 101 | 28 | 8 | 246 | 81 |
| Rhode Island | 1, 733 | 1, 411 | 12 | 34 | 24 | 15 | 114 | 123 |
| South Carolina | 2, 981 | 2, 449 | 51 | 90 | 20 | 14 | 179 | 178 |
| South Dakota | 566 | 496 | 2 | 4 |  | 1 | 26 | 37 |
| Tennessee | 5, 480 | 4, 471 | 113 | 162 | 101 | 30 | 367 | 236 |
| Texas | 15, 440 | 12, 811 | 287 | 344 | 271 | 79 | 824 | 824 |
| Utah | 1, 789 | 1, 481 | 36 | 47 | 39 | 7 | 87 | 92 |
| Vermont | 931 | 697 | 21 | 37 | 37 | 8 | 39 | 92 |
| Virginia | 6, 846 | 5, 467 | 127 | 203 | 103 | 47 | 479 | 420 |
| Virgin Islands | 72 | 60 |  | 1 |  |  | 1 | 10 |
| Washington | 5, 694 | 4, 614 | 86 | 161 | 148 | 22 | 264 | 399 |
| West Virginia | 2, 128 | 1, 740 | 26 | 45 | 17 | 18 | 145 | 137 |
| Wisconsin | 6, 026 | 5, 068 | 97 | 125 | 91 | 53 | 279 | 313 |
| Wyoming | 375 | 315 | 2 | 8 |  | 5 | 17 | 28 |
| Pacific Islands | 55 | 53 |  | 1 |  |  |  | 1 |

Source: "Physician Distribution and Medical Licensure in the U.S., 1974," Center for Health Services Research and Development, AMA, 1975.

The demographic county classification system, as developed by the American Medical Association, is a way of classifying counties in the United States in order to relate the distribution of physicians to the distribution of resident civilian population. Nine classifications are used, ranging from nonmetropolitan counties with 0 to 9,999 inhabitants to counties in standard metropolitan statistical areas (SMSA's) with 5 million or more inhabitants. The distribution of propulation under this system is shown in table 5.

TABLE 5.—*Demographic county classification, Dec. 31, 1974*

| Demographic county classification and definition | Number of SMSA's | Number of counties | Resident population, Dec. 31, 1973 |
|---|---|---|---|
| Total 50 States and District of Columbia | 300 | 3, 084 | 210, 908, 300 |
| 9. Counties in SMSA's with 5,000,000 or more inhabitants | 3 | 16 | 23, 919, 100 |
| 8. Counties in SMSA's with 1,000,000 to 4,999,999 inhabitants | 32 | 163 | 62, 959, 000 |
| 7. Counties in SMSA's with 500,000 to 999,999 inhabitants | 39 | 130 | 27, 690, 700 |
| 6. Counties in SMSA's with 50 000 to 499,999 inhabitants | 179 | 320 | 39, 419, 400 |
| 5. Counties considered potential SMSA's | 47 | 59 | 4, 849, 400 |
| 4. Nonmetropolitan counties with 50,000 or more inhabitants | | 219 | 16, 104, 700 |
| 3. Nonmetropolitan counties with 25,000 to 49,999 inhabitants | | 466 | 16, 254, 800 |
| 2. Nonmetropolitan counties with 10,000 to 24,999 inhabitants | | 929 | 15, 176, 700 |
| 1. Nonmetropolitan counties with 0 to 9,999 inhabitants | | 782 | 4, 534, 500 |

NOTE.—Cities defined as independent are included in "number of counties" column.

Source: "Physician Distribution and Medical Licensure in the U.S., 1974," Center for Health Services Research and Development, AMA, 1975.

An uneven distribution of physicians and other health resources is illustrated by the application of the demographic classification system. Table 6 indicates that 54.6 percent of the Nation's physicians are located in the most densely populated metropolitan areas and serve the needs of 40.4 percent of the resident population. In contrast, only 7.3 percent of the physicians are located in nonmetropolitan areas to serve 17 percent of the population.

Table 6 also indicates that physicians in general practice are more evenly distributed, nationwide, than specialists. A greater percentage of physicians in medical and surgical specialties, in proportion to population, are located in highly urban areas.

Table 6 also shows an uneven distribution of hospitals, and at the same time outlines a rather even distribution of hospital beds. A larger percentage of hospitals are located in rural areas to serve the needs of a relatively smaller population.

Table 6.—*Percentage distribution of non-Federal physicians, hospitals, hospital beds, and population by county classification*

| Demographic county classification | Total physicians, (percent) | Patient care | Office based practice |  |  |  | Hospital based practice | Other professional activity [1] | Inactive | Not classified | Hospitals | Hospital beds | Resident population, (Dec. 31, 1973) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  | General practice | Medical specialty | Surgical specialty | Other specialty |  |  |  |  | (Dec. 1, 1974) |  |  |
| Total | 100. 0 | 100. 0 | 100 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 |
| Possessions | 0. 9 | 0. 9 | 1. 0 | 0. 7 | 0. 6 | 0. 6 | 1. 3 | 0. 8 | 0. 4 | 1. 2 | 0. 9 | 0. 8 | (2) |
| 1 | . 6 | . 6 | 2. 9 | . 2 | . 3 | . 2 | 0. 1 | . 2 | 1. 2 | 0. 4 | 8. 1 | 2. 0 | 2. 1 |
| 2 | 2. 6 | 2. 7 | 9. 8 | 1. 2 | 2. 0 | 1. 4 | . 7 | . 7 | 3. 9 | 1. 6 | 16. 6 | 6. 4 | 7. 2 |
| 3 | 4. 1 | 4. 2 | 9. 4 | 3. 3 | 4. 7 | 3. 4 | 1. 5 | 2. 1 | 5. 9 | 2. 7 | 12. 5 | 7. 7 | 7. 7 |
| 4 | 4. 8 | 4. 9 | 8. 1 | 4. 8 | 6. 3 | 4. 8 | 1. 9 | 2. 5 | 6. 8 | 3. 6 | 8. 7 | 7. 2 | 7. 6 |
| 5 | 1. 8 | 1. 9 | 2. 2 | 1. 9 | 2. 4 | 1. 9 | 1. 2 | 1. 6 | 2. 1 | 1. 4 | 2. 2 | 2. 5 | 2. 3 |
| 6 | 17. 1 | 17. 3 | 16. 9 | 17. 6 | 20. 4 | 18. 6 | 13. 9 | 15. 1 | 18. 9 | 14. 2 | 15. 7 | 19. 9 | 18. 7 |
| 7 | 13. 6 | 13. 6 | 11. 0 | 14. 3 | 14. 4 | 13. 2 | 14. 4 | 14. 0 | 13. 0 | 12. 9 | 8. 1 | 12. 4 | 13. 1 |
| 8 | 37. 4 | 36. 7 | 26. 6 | 38. 2 | 35. 3 | 38. 4 | 42. 4 | 43. 0 | 35. 3 | 41. 7 | 20. 1 | 29. 0 | 29. 9 |
| 9 | 17. 2 | 17. 1 | 12. 2 | 17. 8 | 13. 7 | 17. 3 | 22. 6 | 20. 1 | 12. 6 | 20. 3 | 7. 3 | 12. 2 | 11. 3 |

[1] Includes Medical Teaching, Administration, Research, and other.

[2] Not available.

Note.—Percentages may not add due to rounding.

Table 7 lists 145 counties in the United States which had no active physician in patient care, as of December 31, 1974. This represents an increase of 5 counties since 1972, and 13 since 1970. The 145 counties cover approximately 153,592 square miles, or about 4.3 percent of the total U.S. land area. Over one-half million people, or 0.3 percent of the total population, reside in these counties.

The vast majority of the counties (202) are located in the Western portion of the country. Thirty-nine are adjacent to standard metropolitan statistical areas.

TABLE 7.—*Counties without an active physician in patient care, land area, resident population, and population per square mile*

| State and county, Dec. 31, 1974 | | Square miles | Resident population, Dec. 31, 1973 | Population per square mile |
|---|---|---|---|---|
| Total, 50 States and District of Columbia | 3, 084 | 3, 536, 855 | 210, 908, 300 | 60 |
| Percent | (100. 0) | (100. 0) | (100. 0) | |
| Total counties without a physician | 145 | 153, 592 | 537, 700 | 4 |
| Percent | (4. 7) | (4. 3) | (. 3) | |
| California | | 156, 361 | 20, 705, 100 | 132 |
| Alpine | | 727 | 500 | 1 |
| Colorado | | 103, 766 | 2, 472, 800 | 24 |
| Dolores | | 1, 026 | 1, 200 | 1 |
| Hinsdale | | 1, 054 | 300 | (1) |
| Washington | | 2, 526 | 5, 400 | 2 |
| Florida | | 54, 090 | 7, 841, 600 | 145 |
| Glades | | 753 | 4, 500 | 6 |
| Lafayette | | 549 | 3, 200 | 6 |
| Georgia | | 58, 073 | 4, 816, 200 | 83 |
| Baker | | 355 | 3, 500 | 10 |
| Brantley | | 447 | 7, 000 | 15 |
| Bryan | | 443 | 8, 000 | 18 |
| Dawson | | 211 | 4, 200 | 20 |
| Glascock | | 143 | 2, 300 | 16 |
| McIntosh | | 426 | 8, 800 | 21 |
| Quitman | | 156 | 2, 000 | 13 |
| Schley | | 162 | 3, 000 | 19 |
| Taliaferro | | 195 | 2, 500 | 13 |
| Warren | | 284 | 7, 400 | 26 |
| Webster | | 195 | 2, 100 | 11 |
| Wheeler | | 306 | 4, 800 | 16 |
| Idaho | | 82, 677 | 77, 700 | 9 |
| Adams | | 1, 371 | 2, 900 | 2 |
| Boise | | 1, 910 | 2, 100 | 1 |
| Clark | | 1, 751 | 800 | 1 |
| Owyhee | | 7, 641 | 7, 300 | 1 |
| Kansas | | 81, 787 | 2, 297, 200 | 28 |
| Elk | | 647 | 3, 700 | 6 |
| Gray | | 872 | 4, 700 | 5 |
| Haskell | | 580 | 4, 300 | 7 |
| Kearney | | 855 | 3, 400 | 4 |
| Stanton | | 676 | 2, 500 | 4 |
| Wichita | | 724 | 3, 200 | 4 |
| Kentucky | | 39, 650 | 3, 363, 600 | 85 |
| Carlisle | | 195 | 6, 000 | 31 |
| Lee | | 210 | 6, 800 | 32 |
| Menifee | | 210 | 4, 000 | 19 |
| Robertson | | 101 | 2, 400 | 24 |
| Michigan | | 56, 817 | 9, 092, 800 | 160 |
| Keeweenaw | | 538 | 1, 900 | 4 |
| Montmorency | | 555 | 6, 100 | 11 |

Footnote at end of table.

TABLE 7.—*Counties without an active physician in patient care, land area, resident population, and population per square mile*—Continued

| State and county, Dec. 31, 1974 | Square miles | Resident population, Dec. 31, 1973 | Population per square mile |
|---|---|---|---|
| Mississippi | 47, 296 | 2, 292, 900 | 48 |
| Issaquena | 414 | 2, 800 | 7 |
| Missouri | 68, 995 | 4, 772, 000 | 69 |
| Bollinger | 621 | 9, 300 | 15 |
| Carter | 506 | 4, 200 | 8 |
| Clark | 506 | 8, 500 | 17 |
| Dallas | 537 | 10, 800 | 20 |
| DeKalb | 423 | 7, 300 | 17 |
| Hickory | 377 | 5, 000 | 13 |
| Maries | 525 | 6, 800 | 13 |
| McDonald | 540 | 14, 100 | 26 |
| Mercer | 455 | 5, 000 | 11 |
| Osage | 608 | 11, 400 | 19 |
| Ozark | 732 | 7, 400 | 10 |
| Putnam | 518 | 6, 100 | 12 |
| Reynolds | 817 | 6, 100 | 7 |
| Schuyler | 306 | 5, 300 | 17 |
| Scotland | 441 | 5, 800 | 13 |
| Wayne | 766 | 9, 900 | 13 |
| Montana | 145, 587 | 727, 500 | 5 |
| Golden Valley | 1, 176 | 1, 000 | 1 |
| Judith Basin | 1, 880 | 2, 500 | 1 |
| Meagher | 2, 354 | 2, 300 | 1 |
| Petroleum | 1, 655 | 800 | (1) |
| Treasure | 985 | 1, 100 | 1 |
| Wibaux | 890 | 1, 300 | 1 |
| Nebraska | 76, 483 | 1, 548, 200 | 20 |
| Arthur | 704 | 600 | 1 |
| Banner | 738 | 1, 300 | 2 |
| Blaine | 710 | 700 | 1 |
| Deuel | 436 | 3, 000 | 7 |
| Gosper | 464 | 2, 400 | 5 |
| Greeley | 570 | 4, 000 | 7 |
| Hayes | 711 | 1, 800 | 3 |
| Hitchcock | 712 | 4, 500 | 6 |
| Keya Paha | 768 | 1, 100 | 1 |
| Logan | 570 | 1, 000 | 2 |
| Loup | 574 | 1, 000 | 2 |
| McPherson | 856 | 900 | 1 |
| Sioux | 2, 063 | 2, 100 | 1 |
| Thomas | 716 | 1, 100 | 2 |
| Wheeler | 576 | 1, 000 | 2 |
| Nevada | 109, 889 | 555, 400 | 5 |
| Esmeralda | 3, 570 | 500 | (1) |
| Eureka | 4, 182 | 1, 200 | (1) |
| Lander | 5, 621 | 2, 000 | (1) |
| Storey | 262 | 700 | 3 |
| New Mexico | 121, 412 | 1, 120, 800 | 9 |
| Guadalupe | 2, 998 | 5, 100 | 2 |
| Harding | 2, 134 | 1, 000 | 1 |
| North Dakota | 69, 273 | 642, 900 | 9 |
| Billings | 1, 139 | 1, 200 | 1 |
| Dunn | 1, 992 | 3, 700 | 2 |
| Oliver | 721 | 1, 900 | 3 |
| Sargent | 853 | 5, 200 | 6 |
| Sheridan | 989 | 3, 000 | 3 |
| Slope | 1, 225 | 1, 100 | 1 |
| Ohio | 40, 975 | 10, 759, 700 | 263 |
| Vinton | 411 | 10, 400 | 25 |
| Oklahoma | 68, 782 | 2, 678, 100 | 39 |
| Dewey | 1, 018 | 5, 800 | 6 |
| Oregon | 96, 184 | 2, 247, 500 | 23 |
| Sherman | 830 | 1, 700 | 2 |
| Wheeler | 1, 707 | 1, 500 | 1 |

Footnote at end of table.

TABLE 7.—*Counties without an active physician in patient care, land area, resident population, and population per square mile*—Continued

| State and county, Dec. 31, 1974 | Square miles | Resident population, Dec. 31, 1973 | Population per square mile |
|---|---|---|---|
| South Dakota | 75, 955 | 687, 600 | 9 |
| Aurora | 709 | 4, 700 | 7 |
| Buffalo | 482 | 2, 100 | 4 |
| Campbell | 732 | 3, 700 | 5 |
| Clark | 964 | 4, 700 | 5 |
| Corson | 2, 470 | 4, 900 | 2 |
| Dewey | 2, 351 | 5, 600 | 2 |
| Edmunds | 1, 154 | 4, 700 | 4 |
| Hanson | 430 | 3, 300 | 8 |
| Harding | 2, 682 | 2, 000 | 1 |
| Hyde | 863 | 2, 100 | 2 |
| Jones | 973 | 1, 500 | 2 |
| Mellette | 1, 306 | 2, 400 | 2 |
| Miner | 570 | 4, 200 | 7 |
| Perkins | 2, 860 | 4, 500 | 2 |
| Sanborn | 570 | 3, 200 | 6 |
| Stanley | 1, 414 | 1, 800 | 1 |
| Sully | 1, 004 | 2, 900 | 3 |
| Union | 452 | 9, 200 | 18 |
| Washabaugh | 1, 061 | 1, 900 | 2 |
| Ziebach | 1, 981 | 3, 000 | 2 |
| Tennessee | 41, 328 | 4, 126, 200 | 100 |
| Meigs | 191 | 5, 100 | 27 |
| Union | 212 | 10, 000 | 47 |
| Texas | 262, 134 | 11, 896, 100 | 45 |
| Borden | 907 | 900 | 1 |
| Briscoe | 874 | 2, 300 | 3 |
| Carson | 900 | 6, 900 | 8 |
| Concho | 1, 004 | 2, 100 | 2 |
| Glasscock | 863 | 1, 000 | 1 |
| Hartley | 1, 488 | 2, 400 | 2 |
| Hood | 426 | 6, 800 | 9 |
| Hudspeth | 4, 554 | 2, 000 | (1) |
| Irion | 1, 073 | 1, 100 | 1 |
| Jeff Davis | 2, 259 | 1, 500 | 1 |
| Kenedy | 1, 394 | 700 | 1 |
| Kent | 880 | 1, 300 | 1 |
| King | 944 | 500 | 1 |
| Kinney | 1, 393 | 2, 000 | 1 |
| Lipcomb | 934 | 3, 400 | 4 |
| Loving | 648 | 300 | (1) |
| McMullen | 1, 159 | 1, 500 | 1 |
| Rains | 210 | 4, 200 | 20 |
| Real | 622 | 2, 400 | 4 |
| Roberts | 899 | 1, 400 | 2 |
| San Jacinto | 624 | 6, 300 | 10 |
| Stonewall | 926 | 2, 400 | 3 |
| Terrell | 2, 391 | 1, 100 | (1) |
| Utah | 82, 096 | 1, 166, 900 | 14 |
| Emery | 4, 439 | 5, 000 | 1 |
| Piute | 754 | 1, 200 | 2 |
| Rich | 1, 023 | 2, 000 | 2 |
| Wayne | 2, 486 | 1, 700 | 1 |
| Vermont | 9, 267 | 468, 200 | 51 |
| Grand Isle | 83 | 3, 600 | 43 |
| Virginia | 39, 780 | 4, 833, 300 | 122 |
| Bland | 369 | 5, 900 | 16 |
| Charles City | 181 | 6, 800 | 38 |
| King and Queen | 318 | 5, 300 | 17 |
| West Virgina | 24, 070 | 1, 793, 800 | 75 |
| Clay | 343 | 10, 200 | 30 |
| Doddridge | 319 | 6, 800 | 21 |

Footnote at end of table.

TABLE 7.—*Counties without an active physician in patient care, land area, resident population, and population per square mile*—Continued

| State and county, Dec. 31, 1974 | Square miles | Resident population, Dec. 31, 1973 | Population per square mile |
|---|---|---|---|
| Wisconsin | 54, 464 | 4, 593, 000 | 84 |
| Florence | 487 | 3, 200 | 7 |
| Wyoming | 97, 203 | 356, 600 | 4 |
| Crook | 2, 882 | 3, 900 | 1 |

[1] Less than 0.5.

Sources: U.S. Bureau of the Census, "County and City Data Book, 1972" (A Statistical Abstract Supplement). Washington, D.C.: U.S. Government Printing Office; 1973."1974 Survey of Buying Power," Annual Statistical Issue, Sales Management Inc. Vol. 113, No. 1 July 8, 1974.

In 1972, 52,968 non-Federal physicians in general practice were professionally active in the United States and its possessions. By 1974, that figure had decreased to 51,861. Although total figures for this 3-year span reflect a 9.2-percent decrease in the number of general practitioners nationwide, the actual number of physicians in general practice increased in fifteen States. The number of general practitioners decreased in 29 States during this same period. Hawaii, Kentucky, and New Hampshire showed no change. The changes in eight States were too minute to compute.

Table 8 outlines the distribution of professionally active general practitioners, State by State, for 1968 and 1972.

TABLE 8.—*Distribution of non-Federal physicians in general practice, 1972 and 1974*

| State | 1972 | 1974 | Percent change between 1972 and 1974 |
|---|---|---|---|
| Alabama | 698 | 679 | −3 |
| Alaska | 71 | 73 | +3 |
| Arizona | 517 | 584 | +13 |
| Arkansas | 557 | 582 | +5 |
| California | 6, 735 | 6, 624 | −2 |
| Canal Zone | 6 | 3 | −50 |
| Colorado | 601 | 632 | +5 |
| Connecticut | 636 | 592 | −7 |
| Delaware | 133 | 135 | +2 |
| District of Columbia | 189 | 178 | −6 |
| Florida | 1, 578 | 1, 754 | +11 |
| Georgia | 875 | 881 | +1 |
| Hawaii | 195 | 195 |  |
| Idaho | 255 | 245 | −4 |
| Illinois | 2, 849 | 2, 820 | −1 |
| Indiana | 1, 586 | 1, 592 | +3 |
| Iowa | 869 | 862 | −1 |
| Kansas | 639 | 644 | +1 |
| Kentucky | 859 | 859 |  |
| Louisiana | 801 | 785 | −2 |
| Maine | 251 | 247 | −2 |
| Maryland | 778 | 773 | −1 |
| Massachusetts | 1, 345 | 1, 183 | −12 |
| Michigan | 1, 709 | 1, 652 | −3 |
| Minnesota | 1, 220 | 1, 260 | +3 |
| Mississippi | 541 | 535 | −1 |
| Missouri | 843 | 808 | −4 |
| Montana | 230 | 223 | −3 |
| Nebraska | 517 | 540 | +4 |
| Nevada | 138 | 145 | +5 |
| New Hampshire | 220 | 220 |  |
| New Jersey | 1, 648 | 1, 508 | −9 |
| New Mexico | 185 | 208 | +12 |
| New York | 4, 757 | 4, 253 | −11 |
| North Carolina | 1, 063 | 1, 074 | +1 |
| North Dakota | 169 | 176 | +4 |
| Ohio | 2, 586 | 2, 470 | −5 |
| Oklahoma | 604 | 580 | −4 |
| Oregon | 624 | 638 | +2 |
| Pennsylvania | 3, 187 | 3, 064 | −4 |
| Puerto Rico | 598 | 570 | −5 |
| Rhode Island | 191 | 170 | −11 |
| South Carolina | 680 | 747 | +10 |
| South Dakota | 193 | 184 | −5 |
| Tennessee | 834 | 802 | −4 |
| Texas | 2, 837 | 2, 831 | −2 |
| Utah | 280 | 282 | +1 |
| Vermont | 144 | 127 | −12 |
| Virginia | 1, 110 | 1, 091 | −2 |
| Virgin Islands | 9 | 6 | −33 |
| Washington | 1, 081 | 1, 092 | +1 |
| West Virginia | 424 | 380 | −10 |
| Wisconsin | 1, 189 | 1, 173 | −1 |
| Wyoming | 124 | 119 | −4 |
| Pacific Islands | 10 | 11 | +10 |
| Total | 52, 968 | 51, 861 | −2 |

Source: "Physician Distribution and Medical Licensure in the United States, 1974," AMA, 1975.

Table 9 shows the physician/population ratios for selected years beginning in 1950. Table 10 shows physician/population ratios by State.

TABLE 9.—*Physicians, population and physician/population ratios, selected years, 1950–73*

| Year | Total physicians [1] | Total population [2] (thousands) | Physicians per 100,000 total population | Total population per 1 physician | Non-Federal physician in patient care [3] | Civilian resident population [3] [4] (thousands) | Non-Federal physicians in patient care per 100,000 civilian resident population | Civilian resident population per 1 non-Federal physician in patient care |
|---|---|---|---|---|---|---|---|---|
| 1950 | 219,997 | 156,472 | 141 | 711 | (5) | 151,238 | (5) | (5) |
| 1955 | 241,711 | 170,499 | 142 | 705 | (5) | 164,597 | (5) | (5) |
| 1960 | 260,484 | 185,370 | 141 | 712 | (5) | 179,742 | (5) | (5) |
| 1965 | 292,088 | 199,278 | 147 | 682 | 237,482 | 192,633 | 123 | 811 |
| 1966 | 300,375 | 201,585 | 149 | 671 | 241,730 | 194,355 | 124 | 804 |
| 1967 | 308,630 | 203,704 | 152 | 660 | 247,256 | 196,359 | 126 | 794 |
| 1968 | 317,032 | 205,758 | 154 | 649 | 236,460 | 198,287 | [6] 119 | 839 |
| 1969 | 324,942 | 207,863 | 156 | 640 | 245.368 | 200,466 | 122 | 817 |
| 1970 | 334,028 | 209,539 | 159 | 627 | 252,778 | 203,106 | 124 | 803 |
| 1971 | 344,814 | 211,578 | 163 | 614 | 261,335 | 205,497 | 127 | 786 |
| 1972 | 356,534 | 213,046 | 167 | 598 | 269,095 | 207,313 | 130 | 770 |
| 1973 (estimate) | 366,379 | 214,524 | 171 | 586 | 272,850 | 208,958 | 131 | 766 |

[1] Includes inactive and address unknown as of December 31.

[2] Includes Armed Forces and their dependents in the United States and abroad, civilians in the 50 States, District of Columbia, and U.S. outlying areas; and U.S. Government and civilian employees and their dependents abroad.

[3] Excludes U.S. outlying areas (Canal Zone, Pacific Islands, Puerto Rico, and Virgin Islands).

[4] As of January 1 of following year.

[5] Not available.

[6] In 1968 approximately 21,564 physicians were reclassified by AMA from patient care activities into other activities.

Source: "1974 Socioeconomic Issues of Health," AMA, 1973.

### TABLE 10.—*Non-Federal physicians, civilian population, physician-population ratios and rank by State*

| State | Civilian population (July 1, 1974) | Non-Federal physicians (Dec. 31, 1974) | | Physicians per 100,000 population | | Rank of physician-population ratio by State | |
|---|---|---|---|---|---|---|---|
| | | Total | Patient care | Total | Patient care | Total | Patient care |
| Total (50 States and District of Columbia[1] | 209, 689, 000 | 342, 611 | 276, 070 | 163 | 132 | | |
| Alabama | 3, 551, 000 | 3, 509 | 2, 967 | 99 | 84 | 49 | 47 |
| Alaska | 311, 000 | 302 | 245 | 97 | 77 | 49 | 50 |
| Arizona | 2, 126, 000 | 3, 772 | 2, 876 | 177 | 135 | 11 | 12 |
| Arkansas | 2, 052, 000 | 2, 039 | 1, 699 | 99 | 83 | 47 | 48 |
| California | 20, 610, 000 | 44, 093 | 35, 001 | 214 | 170 | 5 | 5 |
| Colorado | 2, 448, 000 | 4, 488 | 3, 645 | 183 | 149 | 21 | 8 |
| Connecticut | 3, 076, 000 | 6, 646 | 5, 282 | 216 | 172 | 4 | 4 |
| Delaware | 567, 000 | 850 | 709 | 150 | 125 | 20 | 21 |
| District of Columbia | 714, 000 | 3, 249 | 2, 408 | 455 | 337 | 1 | 1 |
| Florida | 8, 002, 000 | 14, 275 | 10, 368 | 178 | 130 | 8 | 18 |
| Georgia | 4, 832, 000 | 5, 916 | 4, 928 | 122 | 102 | 36 | 34 |
| Hawaii | 6, 792, 000 | 1, 412 | 1, 131 | 178 | 143 | 10 | 10 |
| Idaho | 793, 000 | 802 | 683 | 101 | 86 | 46 | 46 |
| Illinois | 11, 096, 000 | 17, 594 | 14, 409 | 159 | 130 | 17 | 17 |
| Indiana | 5, 319, 000 | 5, 919 | 4, 962 | 111 | 93 | 40 | 40 |
| Iowa | 2, 854, 000 | 3, 122 | 2, 614 | 109 | 92 | 42 | 41 |
| Kansas | 2, 240, 000 | 2, 969 | 2, 441 | 133 | 109 | 27 | 27 |
| Kentucky | 3, 321, 000 | 3, 879 | 3, 253 | 117 | 98 | 38 | 38 |
| Louisiana | 3, 733, 000 | 4, 806 | 4, 007 | 129 | 107 | 31 | 30 |
| Maine | 1, 036, 000 | 1, 342 | 1, 071 | 130 | 103 | 30 | 33 |
| Maryland | 4, 041, 000 | 8, 567 | 6, 517 | 212 | 161 | 6 | 6 |
| Massachusetts | 5, 785, 000 | 13, 226 | 10, 228 | 229 | 177 | 3 | 3 |
| Michigan | 9, 084, 000 | 12, 608 | 10, 184 | 139 | 112 | 25 | 25 |
| Minnesota | 3, 915, 000 | 6, 522 | 5, 294 | 167 | 135 | 12 | 13 |
| Mississippi | 2, 302, 000 | 2, 112 | 1, 818 | 92 | 79 | 50 | 49 |
| Missouri | 4, 752, 000 | 6, 741 | 5, 433 | 142 | 114 | 24 | 24 |
| Montana | 729, 000 | 814 | 719 | 112 | 99 | 39 | 36 |
| Nebraska | 1, 531, 000 | 1, 971 | 1, 613 | 129 | 105 | 32 | 31 |
| Nevada | 564, 000 | 695 | 587 | 123 | 104 | 35 | 32 |
| New Hampshire | 803, 000 | 1, 247 | 1, 014 | 155 | 126 | 18 | 20 |
| New Jersey | 7, 300, 000 | 12, 102 | 9, 884 | 166 | 135 | 14 | 11 |
| New Mexico | 1, 107, 000 | 1, 401 | 1, 090 | 127 | 98 | 33 | 37 |
| New York | 18, 083, 000 | 45, 026 | 35, 874 | 249 | 198 | 2 | 2 |
| North Carolina | 5, 265, 000 | 6, 614 | 5, 286 | 126 | 100 | 34 | 35 |
| North Dakota | 624, 000 | 632 | 538 | 101 | 86 | 45 | 45 |
| Ohio | 10, 723, 000 | 15, 383 | 12, 938 | 143 | 121 | 23 | 22 |
| Oklahoma | 2, 680, 000 | 2, 892 | 130 | 108 | 91 | 43 | 42 |
| Oregon | 2, 263, 000 | 3, 736 | 3, 038 | 165 | 134 | 15 | 15 |
| Pennsylvania | 11, 824, 000 | 19, 349 | 15, 866 | 164 | 134 | 16 | 16 |
| Rhode Island | 930, 000 | 1, 733 | 1, 411 | 186 | 152 | 8 | 7 |
| South Carolina | 2, 711, 000 | 2, 981 | 2, 449 | 110 | 90 | 41 | 43 |
| South Dakota | 676, 000 | 566 | 496 | 84 | 73 | 51 | 50 |
| Tennessee | 4, 108, 000 | 5, 480 | 4, 471 | 133 | 109 | 26 | 28 |
| Texas | 11, 890, 000 | 15, 440 | 12, 811 | 130 | 108 | 29 | 29 |
| Utah | 1, 169, 000 | 1, 789 | 1, 481 | 153 | 127 | 19 | 19 |
| Vermont | 470, 000 | 931 | 697 | 198 | 148 | 7 | 9 |
| Virginia | 4, 7511000 | 6, 846 | 5, 467 | 144 | 115 | 22 | 23 |
| Washington | 3, 427, 000 | 5, 694 | 4, 614 | 166 | 135 | 13 | 14 |
| West Virginia | 1, 790, 000 | 2, 128 | 1, 740 | 119 | 97 | 37 | 39 |
| Wisconsin | 4, 565, 000 | 6, 026 | 5, 068 | 132 | 111 | 28 | 26 |
| Wyoming | 356, 000 | 375 | 315 | 105 | 88 | 44 | 44 |

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[1] Excludes physicians (2,996 total non-Federal and 2,447 patient care and population in possessions Canal Zone, Pacific Islands, Puerto Rico, and Virgin Islands. Population total does not add due to rounding.

Source: Estimates of the Population of States: July 1, 1973 and 1974 (Advance Report. "*Current Population Reports*" Series P–25, No. 533, October 1974.

The data presented in the preceding pages relates to doctors of medicine (M.D.). Table 11 outlines the numbers and distribution of doctors of osteopathy, by State, for 1975. Doctors of osteopathy (D.O.) are licensed in most States to practice medicine and surgery on the same basis as M.D.'s. D.O.'s tend to be concentrated in four States—Michigan, Missouri, Ohio, and Pennsylvania. These States account for over 44 percent of the total number of osteopaths in the United States.

TABLE 11.—*Distribution of osteopathic physicians, 1975*

| *Location* | *Number* |
|---|---|
| Alabama | 5 |
| Alaska | 5 |
| Arizona | 413 |
| Arkansas | 16 |
| California | 232 |
| Colorado | 273 |
| Connecticut | 44 |
| Delaware | 45 |
| District of Columbia | 7 |
| Florida | 883 |
| Georgia | 121 |
| Hawaii | 21 |
| Idaho | 26 |
| Illinois | 337 |
| Indiana | 182 |
| Iowa | 414 |
| Kansas | 203 |
| Kentucky | 39 |
| Louisiana | 19 |
| Maine | 205 |
| Maryland | 32 |
| Massachusetts | 182 |
| Michigan | 2, 447 |
| Minnesota | 66 |
| Mississippi | 3 |
| Missouri | 1, 144 |
| Montana | 29 |
| Nebraska | 32 |
| Nevada | 28 |
| New Hampshire | 19 |
| New Jersey | 898 |
| New Mexico | 138 |
| New York | 622 |
| North Carolina | 28 |
| North Dakota | 8 |
| Ohio | 1, 245 |
| Oklahoma | 458 |
| Oregon | 183 |
| Pennsylvania | 1, 825 |
| Rhode Island | 86 |
| South Carolina | 10 |
| South Dakota | 29 |
| Tennessee | 59 |
| Texas | 885 |
| Utah | 17 |
| Vermont | 40 |
| Virginia | 44 |
| Washington | 204 |
| West Virginia | 87 |
| Wisconsin | 182 |
| Wyoming | 10 |
| Canada | 76 |
| Foreign | 70 |
| In military service | 253 |
| Total | 14, 929 |

Source: "1975 American Osteopathic Association Yearbook and Directory of Osteopathic Physicians." Figures include only osteopaths with a directory listing. Members and nonmembers of AOA are included.

## B. Foreign Medical Graduates

As of Dec. 31, 1973, there were 71,335 graduates of foreign medical schools (FMG's) in the United States (excluding Canadian graduates). The greatest number graduated from schools in the Philippines (13.4 percent), and India (10.2 percent). Table 12 presents data on FMG's in the United States by country of graduation.

Table 12.—*Foreign medical graduates by country of graduation, Dec. 31, 1973*

| Country | Total physicians Number | Total physicians Percent |
|---|---|---|
| Total physicians | 71,335 | 100.0 |
| Afghanistan | 27 | (1) |
| Algeria | 1 | (1) |
| Argentina | 1,663 | 2.3 |
| Australia | 375 | .5 |
| Austria | 1,619 | 2.3 |
| Bangladesh | 43 | .1 |
| Belgium | 611 | .9 |
| Bolivia | 212 | .3 |
| Brazil | 580 | .8 |
| Bulgaria | 67 | .1 |
| Burma | 182 | .3 |
| Cambodia | 3 | (1) |
| Ceylon | 307 | .4 |
| Chile | 323 | .5 |
| China | 646 | .9 |
| Colombia | 1,214 | 1.7 |
| Congo (Kinshasa) | 1 | (1) |
| Costa Rica | 36 | .1 |
| Cuba | 3,112 | 4.4 |
| Czechoslovakia | 702 | 1.0 |
| Denmark | 83 | .1 |
| Dominican Republic | 763 | 1.1 |
| East Germany | 660 | .9 |
| Ecuador | 197 | .3 |
| El Salvador | 145 | .2 |
| Ethiopia | 2 | (1) |
| Finland | 37 | .1 |
| France | 727 | 1.0 |
| Greece | 950 | 1.3 |
| Guatemala | 154 | .2 |
| Haiti | 405 | .6 |
| Honduras | 69 | .1 |
| Hong Kong | 139 | .2 |
| Hungary | 854 | 1.2 |
| Iceland | 43 | .1 |
| India | 7,244 | 10.2 |
| Indonesia | 156 | .2 |
| Iran | 2,229 | 3.1 |
| Iraq | 245 | .3 |
| Ireland | 1,032 | 1.5 |
| Israel | 303 | .4 |
| Italy | 3,502 | 4.9 |
| Jamaica | 91 | .1 |
| Japan | 871 | 1.2 |
| Lebanon | 719 | 1.0 |
| Malaysia | 6 | (1) |
| Malta | 6 | (1) |
| Mexico | 2,223 | 3.1 |
| Netherlands | 741 | 1.0 |
| New Zealand | 100 | 0.1 |
| Nicaragua | 103 | 0.1 |
| Nigeria | 73 | 0.1 |
| North Korea | 2 | (1) |
| North Vietnam | 3 | (1) |
| Norway | 52 | 0.1 |
| Pakistan | 1,249 | 1.8 |
| Panama | 36 | 0.1 |
| Paraguay | 117 | 0.2 |
| Peru | 785 | 1.1 |
| Philippines | 9,533 | 13.4 |
| Poland | 773 | 1.1 |
| Portugal | 108 | 0.2 |
| Rumania | 406 | 0.6 |
| Senegal | 1 | (1) |
| Singapore | 40 | 0.1 |
| South Africa | 411 | 0.6 |
| South Korea | 3,132 | 4.4 |
| South Vietnam | 21 | (1) |
| Spain | 2,231 | 3.1 |
| Sudan | 2 | (1) |
| Surinam | 3 | (1) |
| Sweden | 76 | 0.1 |
| Switzerland | 2,511 | 3.5 |
| Syria | 370 | 0.5 |
| Taiwan (Formosa) | 1,711 | 2.4 |
| Thailand | 1,308 | 1.8 |
| Turkey | 995 | 1.4 |
| Uganda | 42 | 0.1 |
| U.S.S.R. | 759 | 1.1 |
| United Arab Republic (Egypt) | 1,103 | 1.6 |
| United Kingdom | 2,742 | 3.8 |
| Uruguay | 70 | 0.1 |
| Venezuela | 254 | 0.4 |
| West Germany | 3,383 | 4.7 |
| Yugoslavia | 510 | 0.7 |

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[1] Less than 0.05 percent.

Source: Martin, Beverly, C., "Medical School Alumni," Center for Health Services Research and Development, American Medical Association, 1975.

In the 11-year span between 1962 and 1973, approximately 101,000 foreign physicians were admitted to the United States. During that same period, U.S. medical school graduated almost 98,000 medical students. Table 13 indicates that in 1962. U.S. medical schools graduated 24 percent more physicians than were admitted from foreign nations. Eleven years later, however, 18 percent more FMG's were entering the United States than were graduated from U.S. medical schools. The number of foreign physicians admitted to the United States with immigrant status grew remarkably between 1962 and 1973—from 1,297 to 7,119. Table 13 also outlines the entry status of FMG's during this period.

Table 14 shows physicians and surgeons admitted as immigrants to the United States by country of last permanent residence for the fiscal years 1966, 1969, and 1972. The vast majority of FMG's admitted as immigrants in 1972 were from Asian countries. India led the list with over 1,500 physicians admitted with immigrant status from that country in fiscal year 1972.

TABLE 13.—*Foreign physicians and surgeons admitted to the United States in comparison with number of U.S. medical graduates: 1962–73*

| | | Foreign physicians [1] | | | |
|---|---|---|---|---|---|
| | | | | Nonimmigrants | |
| Fiscal year | U.S. medical graduates | Total | Immigrants | Exchange visitors | Other |
| Total | 97, 809 | 101, 066 | 43, 089 | 55, 360 | 2, 617 |
| 1962 | 7, 168 | 5, 767 | 1, 797 | 3, 970 | NA |
| 1963 | 7, 264 | 6, 730 | 2, 093 | 4, 637 | NA |
| 1964 | 7, 336 | 6, 767 | 2, 249 | 4, 518 | NA |
| 1965 | 7, 409 | 6, 172 | 2, 012 | 4, 160 | NA |
| 1966 | 7, 574 | 6, 922 | 2, 552 | 4, 370 | NA |
| 1967 | 7, 743 | 8, 897 | 3, 326 | 5, 204 | 367 |
| 1968 | 7, 973 | 9, 125 | 3, 128 | 5, 701 | 296 |
| 1969 | 8, 059 | 7, 515 | 2, 756 | 4, 460 | 299 |
| 1970 | 8, 367 | 8, 523 | 3, 158 | 5, 008 | 357 |
| 1971 | 8, 974 | 10, 947 | 5, 756 | 4, 784 | 407 |
| 1972 | 9, 551 | 11, 416 | 7, 143 | 3, 935 | 338 |
| 1973 | 10, 391 | 12, 285 | 7, 119 | 4, 613 | 553 |

[1] Including Canadians.

Source: Reference 22. Unpublished data from the U.S. Department of Justice Immigration and Naturalization Service.

TABLE 14.—*Physicians and surgeons admitted as immigrants by country of last permanent residence*

| | Selected fiscal years | | |
|---|---|---|---|
| | 1966 | 1969 | 1972 |
| Europe: | | | |
| Austria | 16 | 49 | 15 |
| Belgium | 17 | 6 | 14 |
| Czechoslovakia | 5 | 10 | 24 |
| Germany | 81 | 52 | 72 |
| Greece | 38 | 36 | 64 |
| Ireland | 22 | 18 | 26 |
| Italy | 43 | 51 | 32 |
| Poland | 22 | 21 | 25 |
| Spain | 53 | 51 | 58 |
| Sweden | 20 | 8 | 17 |
| Switzerland | 27 | 12 | 25 |
| Turkey | 57 | 42 | 50 |
| United Kingdom | 187 | 140 | 364 |
| Yugoslavia | 12 | 36 | 33 |
| Other | 67 | 47 | 78 |
| Total | 667 | 579 | 911 |

TABLE 14.—*Physicians and surgeons admitted as immigrants by country of last permanent residence*—Continued

| | Selected fiscal years | | |
|---|---|---|---|
| | 1966 | 1969 | 1972 |
| Americas: | | | |
| Argentina | 115 | 42 | 45 |
| Bolivia | 19 | 13 | 23 |
| Brazil | 33 | 7 | 12 |
| Canada | 393 | 236 | 439 |
| Chile | 11 | 8 | 13 |
| Colombia | 80 | 47 | 82 |
| Cuba | 150 | 54 | 55 |
| Dominican Republic | | 21 | 40 |
| Ecuador | 23 | 29 | 23 |
| Guatemala | 8 | 8 | 13 |
| Haiti | 29 | 27 | 21 |
| Jamaica | 15 | 14 | 18 |
| Peru | 46 | 14 | 36 |
| Other | 288 | 67 | 139 |
| Total | 1, 210 | 587 | 959 |
| Asia: | | | |
| Burma | 5 | 24 | 28 |
| China (Mainland) | 5 | 13 | 68 |
| Hong Kong | 26 | 39 | 45 |
| India | 40 | 129 | 1, 513 |
| Indonesia | | 28 | 27 |
| Iran | 78 | 99 | 459 |
| Iraq | 5 | 3 | 33 |
| Israel | 31 | 30 | 62 |
| Japan | 31 | 28 | 61 |
| Korea | 35 | 128 | 768 |
| Lebanon | 14 | 30 | 53 |
| Pakistan | 11 | 22 | 201 |
| Philippines | 259 | 785 | 782 |
| Syria | 9 | 8 | 19 |
| Thailand | 11 | 12 | 268 |
| Taiwan | 11 | 27 | 470 |
| Other | 17 | 2 | 139 |
| Total | 588 | 1, 435 | 4, 996 |
| Africa: | | | |
| Egypt | 23 | 96 | 63 |
| Kenya | 1 | 6 | 13 |
| Libya | 1 | 3 | 18 |
| Nigeria | 2 | 2 | 21 |
| South Africa | 15 | 8 | 36 |
| Tanzania | | 2 | 19 |
| Uganda | | | 24 |
| Other | 18 | 22 | 31 |
| Total | 60 | 137 | 222 |
| Oceania: | | | |
| Australia | 21 | 14 | 43 |
| New Zealand | 2 | 4 | 12 |
| Other | 1 | | |
| Total | 24 | 18 | 55 |
| Other | 3 | | |
| Grand total | 2, 552 | 2, 756 | 7, 143 |

Source: "The Foreign Medical Graduate and Physicians Manpower in the United States," DHEW, August 1973. "Scientists, Engineers, and Physicians from Abroad," fiscal years 1966 and 1967, NSF 69–10, p. 12, Washington, Government Printing Office, 1969; National Science Foundation, Immigration, tables D1 and D2.

Like U.S. physicians, the great majority of FMG's are specialists. Only 10 percent of the FMG's in the United States, as of December 31, 1973, were in general practice. The data also indicates that more FMG's treat patients in a hospital-based, rather than office-based, setting. Table 15 outlines the number of FMG's in the United States and possessions by specialty group. Table 16 outlines the number of FMG's in the United States and possessions by major professional activity.

TABLE 15.—*Foreign medical graduates by specialty, Dec. 31, 1973*

| *Specialty group* | *Foreign schools* |
|---|---|
| Total physicians [1] | 71, 335 |
| General practice | 7, 287 |
| Internal medicine [2] | 11, 720 |
| Surgery [3] | 11, 078 |
| Obstetrics-gynecology | 3, 799 |
| Pediatrics [4] | 4, 593 |
| Psychiatry [5] | 6, 086 |
| Radiology [6] | 2, 589 |
| Anesthesiology | 4, 251 |
| Pathology [7] | 3, 880 |
| Other [8] | 7, 226 |

[1] Includes inactive, not classified and physicians classified as address unknown who are not distributed throughout table.

[2] Includes internal medicine, allergy, cardiovascular diseases, gastroenterology and pulmonary diseases.

[3] Includes general surgery, neurological surgery, ophthalmology, orthopedic surgery, otolaryngology, plastic surgery, colon and rectal surgery, thoracic surgery and urology.

[4] Includes pediatrics, pediatric allergy and pediatric cardiology.

[5] Includes psychiatry and child psychiatry.

[6] Includes radiology, diagnostic radiology, and therapeutic radiology.

[7] Includes pathology and forensic pathology.

[8] Includes dermatology, aerospace medicine, neurology, occupational medicine, physical medicine and rehabilitation, general preventive medicine, public health, as well as other or unspecified specialties.

Source: Martin, Beverly, C., Medical School Alumni, Center for Health Services Research and Development, American Medical Association 1975.

TABLE 16.—*Foreign medical graduates by major professional activity*

| *Activity* | *Foreign schools* |
|---|---|
| Physicians | 71, 335 |
| Patient care | 57, 337 |
| Office based | 27, 270 |
| Hospital based | 30, 067 |
| Interns | 3, 556 |
| Residents | 15, 637 |
| Physician staff | 20, 874 |
| Other professional activity | 5, 172 |
| Not classified | 4, 922 |
| Inactive | 2, 115 |
| Address unknown | 1, 789 |

Source: Martin, Beverly, C., Medical School alumni, Center for Health Services Research and Development, American Medical Association, 1975.

TABLE 17.—*Foreign medical graduates in the United States, by specialty and activity (excludes Canadian graduates), Dec. 31, 1970*

| Specialty | Total physicians | Major professional activity | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Patient care | | | | | Other professional activity | | | |
| | | | | Hospital based practice | | | | | | |
| | | Total | Office-based practice | Interns | Residents | Full-time physician staff | Medical teaching | Administration | Research | Other |
| Total physicians | 57,217 | 48,191 | 20,980 | 3,050 | 13,598 | 10,563 | 1,006 | 1,194 | 3,285 | 466 |
| General practice | 6,742 | 6,591 | 5,144 | 60 | 290 | 1,097 | 8 | 48 | 55 | 40 |
| Medical specialties | 2,999 | 11,345 | 4,783 | 414 | 3,641 | 2,507 | 247 | 185 | 1,150 | 72 |
| Allergy | 191 | 153 | 119 | ---------- | 13 | 21 | 4 | ---------- | 33 | 1 |
| Cardiovascular diseases | 1,249 | 931 | 423 | ---------- | 270 | 238 | 43 | 16 | 241 | 18 |
| Dermatology | 388 | 345 | 252 | ---------- | 68 | 25 | 6 | 8 | 26 | 3 |
| Gastroenterology | 390 | 276 | 104 | ---------- | 107 | 65 | 18 | 1 | 93 | 2 |
| Internal medicine | 6,372 | 5,832 | 2,373 | 293 | 1,987 | 1,179 | 63 | 80 | 373 | 24 |
| Pediatrics | 3,542 | 3,139 | 1,290 | 121 | 1,034 | 694 | 84 | 51 | 251 | 17 |
| Pediatric allergy | 80 | 67 | 40 | ---------- | 19 | 8 | 2 | ---------- | 11 | ---------- |
| Pediatric cardiology | 169 | 113 | 37 | ---------- | 40 | 36 | 12 | 1 | 41 | 2 |
| Pulmonary diseases | 618 | 489 | 145 | ---------- | 103 | 241 | 15 | 28 | 81 | 5 |
| Surgical specialties | 12, 471 | 11, 691 | 5, 330 | 263 | 4, 230 | 1, 868 | 148 | 101 | 475 | 56 |
| General surgery | 5, 286 | 5, 032 | 1, 688 | 229 | 2, 219 | 896 | 37 | 41 | 150 | 26 |
| Neurological surgery | 409 | 368 | 178 | ---------- | 134 | 56 | 8 | 3 | 29 | 1 |
| Obstetrics and gynecology | 3, 064 | 2, 854 | 1, 405 | 34 | 979 | 436 | 46 | 35 | 117 | 12 |
| Ophthalmology | 810 | 723 | 523 | ---------- | 127 | 73 | 8 | 5 | 70 | 4 |
| Orthopedic surgery | 882 | 839 | 463 | ---------- | 242 | 134 | 13 | 2 | 24 | 4 |
| Otolaryngology | 641 | 585 | 386 | ---------- | 138 | 61 | 13 | 4 | 35 | 4 |
| Plastic surgery | 213 | 200 | 106 | ---------- | 68 | 26 | 2 | 1 | 10 | ---------- |
| Colon and rectal surgery | 62 | 61 | 41 | ---------- | 14 | 6 | ---------- | ---------- | 1 | ---------- |
| Thoracic surgery | 365 | 331 | 156 | ---------- | 91 | 84 | 9 | 2 | 20 | 3 |
| Urology | 739 | 698 | 384 | ---------- | 218 | 96 | 12 | 8 | 19 | 2 |

TABLE 17.—*Foreign medical graduates in the United States, by specialty and activity (excludes Canadian graduates), Dec. 31, 1970*—Continued

| Specialty | Total physicians | Major professional activity | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Patient care | | | | | Other professional activity | | | |
| | | | | Hospital based practice | | | | | | |
| | | Total | Office-based practice | Interns | Residents | Full-time physician staff | Medical teaching | Adminis-tration | Research | Other |
| Other specialties | 21, 930 | 18, 564 | 5, 723 | 2, 313 | 5, 437 | 5, 091 | 603 | 860 | 1, 605 | 298 |
| Aerospace medicine | 32 | 19 | 8 | ---------- | 5 | 6 | 1 | 4 | 5 | 3 |
| Anesthesiology | 3, 304 | 3, 050 | 1, 697 | ---------- | 744 | 609 | 110 | 27 | 111 | 6 |
| Child psychiatry | 425 | 356 | 163 | ---------- | 86 | 107 | 12 | 20 | 30 | 7 |
| Diagnostic radiology | 336 | 302 | 124 | ---------- | 80 | 98 | 17 | 3 | 8 | 6 |
| Forensic pathology | 42 | 21 | 13 | ---------- | 3 | 5 | 2 | 5 | 6 | 8 |
| Neurology | 624 | 480 | 158 | ---------- | 202 | 120 | 35 | 8 | 96 | 5 |
| Occupational medicine | 179 | 136 | 129 | ---------- | 1 | 6 | 2 | 34 | 4 | 3 |
| Psychiatry | 5, 025 | 4, 438 | 1, 608 | ---------- | 939 | 1, 891 | 70 | 348 | 146 | 23 |
| Pathology | 3, 132 | 2, 488 | 504 | 46 | 1, 060 | 878 | 144 | 89 | 278 | 133 |
| General preventive medicine | 90 | 45 | 30 | ---------- | 3 | 12 | 7 | 22 | 12 | 4 |
| Physical medicine and rehabilitation | 501 | 472 | 107 | ---------- | 153 | 212 | 5 | 15 | 8 | 1 |
| Public health | 261 | 100 | 77 | ---------- | 4 | 19 | 12 | 113 | 24 | 12 |
| Radiology | 1, 407 | 1, 284 | 457 | ---------- | 461 | 366 | 38 | 7 | 46 | 32 |
| Therapeutic radiology | 209 | 195 | 83 | ---------- | 56 | 56 | 8 | 1 | 5 | ---------- |
| Other specialty | 2, 470 | 1, 435 | 367 | ---------- | 685 | 383 | 120 | 138 | 744 | 33 |
| Unspecified | 3, 893 | 3, 743 | 198 | 2, 267 | 955 | 323 | 20 | 26 | 82 | 22 |
| Not classified | 276 | | | | | | | | | |
| Inactive | 1, 821 | | | | | | | | | |
| Address unknown | 978 | | | | | | | | | |

Source: "Foreign Medical Graduates in the United States," AMA 1970.

Tables 18 and 19 present data on the age and sex of FMG's in the United States. Approximately two-thirds of the FMG's in the United States, as of 1973 were between the ages of 30 and 50. A greater percentage (16.6 percent) were women, compared to United States (6.3 percent) and Canadian (7.3 percent) graduates.

TABLE 18.—*Physicians by age and country of medical school, Dec. 31, 1973*

| Age | All schools (100 percent) | Country of medical school | | | | | |
|---|---|---|---|---|---|---|---|
| | | U.S. schools [1] | | Canadian schools | | Foreign schools | |
| | | Number | Percent | Number | Percent | Number | Percent |
| Total physicians | 366, 379 | 288, 719 | 78. 8 | 6, 325 | 1. 7 | 71, 335 | 19. 5 |
| Under 30 | 43, 104 | 34, 234 | 79. 4 | 363 | . 8 | 8, 507 | 19. 7 |
| 30 to 34 | 53, 432 | 37, 329 | 69. 9 | 694 | 1. 3 | 15, 409 | 28. 8 |
| 35 to 39 | 47, 676 | 34, 208 | 71. 8 | 823 | 1. 7 | 12, 645 | 26. 5 |
| 40 to 44 | 43, 709 | 32, 683 | 74. 8 | 913 | 2. 1 | 10, 113 | 23. 1 |
| 45 to 49 | 41, 103 | 31, 834 | 77. 4 | 720 | 1. 8 | 8, 549 | 20. 8 |
| 50 to 54 | 36, 974 | 31, 203 | 84. 4 | 619 | 1. 7 | 5, 152 | 13. 9 |
| 55 to 59 | 28, 520 | 25, 023 | 87. 7 | 531 | 1. 9 | 2, 966 | 10. 4 |
| 60 to 64 | 25, 031 | 21, 042 | 84. 1 | 516 | 2. 1 | 3, 473 | 13. 9 |
| 65 to 69 | 19, 492 | 17, 181 | 88. 1 | 409 | 2. 1 | 1, 902 | 9. 8 |
| 70 to 74 | 12, 449 | 10, 784 | 86. 6 | 432 | 3. 5 | 1, 233 | 9. 9 |
| 75 and over | 14, 889 | 13, 198 | 88. 6 | 305 | 2. 0 | 1, 386 | 9. 3 |

[1] Includes active and extinct medical schools.

Note: Percentages may not add due to rounding.

Source: Martin, Beverly, C., Medical School Alumni, Center for Health Services Research and Development, American Medical Association, 1975.

TABLE 19.—*Physicians in the United States by country of graduation and sex, Dec. 31, 1973*

| Country of medical school | Total physicians (100 percent) | Male | | Female | |
|---|---|---|---|---|---|
| | | Number | Percent | Number | Percent |
| All schools | 366, 379 | 335, 811 | 91. 7 | 30, 568 | 8. 3 |
| U.S. schools | 288, 719 | 270, 423 | 93 7 | 18, 296 | 6. 3 |
| Active | 286, 741 | 268, 567 | 93. 7 | 18, 174 | 6. 3 |
| Extinct | 1, 978 | 1, 856 | 93. 8 | 122 | 6. 2 |
| Canadian schools | 6, 325 | 5, 865 | 92. 7 | 460 | 7. 3 |
| Foreign schools | 71, 335 | 59, 523 | 83. 4 | 11, 812 | 16. 6 |

NOTE.—Percentages may not add due to rounding.

Source: Martin, Beverly, C., Medical School Alumni, Center for Health Services Research and Development, American Medical Association, 1975.

New York had the largest percentage of FMG's in 1970. Of the total number of physicians located in New York, 35.6 percent were foreign. In four other States—Delaware, Illinois, New Jersey, and Rhode Island—FMG's accounted for over 25 percent of the total number of physicians. Table 20 shows the distribution of FMG's by State, 1970.

TABLE 20.—*Physicians in the United States by State of practice and country of graduation, Dec. 31, 1970*

| State | Total (100 percent) | Country of graduation | | | | | |
|---|---|---|---|---|---|---|---|
| | | United States | | Foreign | | Canada | |
| | | Number | Percent | Number | Percent | Number | Percent |
| Total | 334, 028 | 270, 637 | 81. 0 | 57, 217 | 17. 1 | 6, 174 | 1. 8 |
| Alabama | 3, 377 | 3, 219 | 95. 3 | 147 | 4. 4 | 11 | 0. 3 |
| Alaska | 324 | 303 | 93. 5 | 17 | 5. 2 | 4 | 1. 2 |
| Arizona | 2, 938 | 2, 608 | 88. 8 | 282 | 9. 6 | 48 | 1. 6 |
| Arkansas | 1, 955 | 1, 924 | 98. 4 | 25 | 1. 3 | 6 | . 3 |
| California | 41, 640 | 37, 476 | 90. 0 | 2, 980 | 7. 2 | 1, 184 | 2. 8 |
| Colorado | 4, 386 | 4, 076 | 92. 9 | 259 | 5. 9 | 51 | 1. 2 |
| Connecticut | 6, 072 | 4, 617 | 76. 0 | 1, 267 | 20. 9 | 188 | 3. 1 |
| Delaware | 783 | 543 | 69. 3 | 217 | 27. 7 | 23 | 2. 9 |
| District of Columbia | 4, 073 | 3, 253 | 79. 9 | 778 | 19. 1 | 42 | 1. 0 |
| Florida | 11, 451 | 9, 513 | 83. 1 | 1, 769 | 15. 4 | 169 | 1. 5 |
| Georgia | 5, 546 | 5, 088 | 91. 7 | 434 | 7. 8 | 24 | . 4 |
| Hawaii | 1, 235 | 999 | 80. 9 | 203 | 16. 4 | 33 | 2. 7 |
| Idaho | 718 | 697 | 97. 1 | 11 | 1. 5 | 10 | 1. 4 |
| Illinois | 16, 323 | 11, 608 | 71. 1 | 4, 542 | 27. 8 | 173 | 1. 1 |
| Indiana | 5, 470 | 4, 954 | 90. 6 | 473 | 8. 6 | 43 | . 8 |
| Iowa | 3, 061 | 2, 708 | 88. 5 | 323 | 10. 6 | 30 | 1. 0 |
| Kansas | 2, 910 | 2, 582 | 88. 7 | 299 | 10. 3 | 29 | 1. 0 |
| Kentucky | 3, 560 | 3, 192 | 89. 7 | 346 | 9. 7 | 22 | . 6 |
| Louisiana | 4, 768 | 4, 476 | 93. 9 | 261 | 5. 5 | 31 | . 7 |
| Maine | 1, 186 | 903 | 76. 1 | 174 | 14. 7 | 109 | 9. 2 |
| Maryland | 9, 518 | 7, 140 | 75. 0 | 2, 249 | 23. 6 | 129 | 1. 4 |
| Massachusetts | 12, 576 | 10, 227 | 81. 3 | 1, 998 | 15. 9 | 351 | 2. 8 |
| Michigan | 11, 364 | 8, 559 | 75. 3 | 2, 376 | 20. 9 | 429 | 3. 8 |
| Minnesota | 6, 145 | 5, 303 | 86. 3 | 645 | 10. 5 | 197 | 3. 2 |
| Mississippi | 2, 077 | 2, 001 | 96. 3 | 67 | 3. 2 | 9 | . 4 |
| Missouri | 6, 314 | 5, 283 | 83. 7 | 982 | 15. 6 | 49 | . 8 |
| Montana | 787 | 743 | 94. 4 | 30 | 3. 8 | 14 | 1. 8 |
| Nebraska | 1, 855 | 1, 777 | 95. 8 | 70 | 3. 8 | 8 | . 4 |
| Nevada | 595 | 557 | 93. 6 | 14 | 2. 4 | 24 | 4. 0 |
| New Hampshire | 1, 098 | 857 | 78. 1 | 145 | 13. 2 | 96 | 8. 7 |
| New Jersey | 10, 923 | 7, 565 | 69. 3 | 3, 224 | 29. 5 | 134 | 1. 2 |
| New Mexico | 1, 390 | 1, 242 | 89. 4 | 127 | 9. 1 | 21 | 1. 5 |
| New York | 44, 800 | 27, 795 | 62. 0 | 15, 946 | 35. 6 | 1, 059 | 2. 4 |
| North Carolina | 6, 069 | 5, 696 | 93. 9 | 311 | 5. 1 | 62 | 1. 0 |
| North Dakota | 660 | 528 | 80. 0 | 91 | 13. 8 | 41 | 6. 2 |
| Ohio | 14, 740 | 10, 996 | 74. 6 | 3, 516 | 23. 9 | 228 | 1. 5 |
| Oklahoma | 2, 899 | 2, 775 | 95. 7 | 105 | 3. 6 | 19 | . 7 |
| Oregon | 3, 181 | 2, 981 | 93. 7 | 141 | 4. 4 | 59 | 1. 9 |
| Pennsylvania | 18, 712 | 15, 779 | 84. 3 | 2, 710 | 14. 5 | 223 | 1. 2 |
| Rhode Island | 1, 638 | 1, 084 | 66. 2 | 495 | 30. 2 | 59 | 3. 6 |
| South Carolina | 2, 670 | 2, 560 | 95. 9 | 99 | 3. 7 | 11 | . 4 |
| South Dakota | 629 | 556 | 88. 4 | 70 | 11. 1 | 3 | . 5 |
| Tennessee | 5, 022 | 4, 698 | 93. 5 | 306 | 6. 1 | 18 | . 4 |
| Texas | 14, 952 | 13, 307 | 89. 0 | 1, 540 | 10. 3 | 105 | . 7 |
| Utah | 1, 569 | 1, 508 | 96. 1 | 43 | 2. 7 | 18 | 1. 1 |
| Vermont | 868 | 756 | 87. 1 | 71 | 8. 2 | 41 | 4. 7 |
| Virginia | 6, 552 | 5, 588 | 85. 4 | 896 | 13. 7 | 68 | 1. 0 |
| Washington | 5, 562 | 4, 939 | 88. 8 | 429 | 7. 7 | 194 | 3. 5 |
| West Virginia | 1, 946 | 1, 465 | 75. 3 | 463 | 23. 8 | 18 | . 9 |
| Wisconsin | 5, 588 | 4, 893 | 87. 6 | 642 | 11. 5 | 53 | . 9 |
| Wyoming | 364 | 346 | 95. 1 | 13 | 3. 6 | 5 | 1. 4 |
| Possessions | 2, 836 | 1, 412 | 49. 8 | 1, 414 | 49. 9 | 10 | . 4 |
| APO–FPO | 3, 149 | 2, 912 | 92. 5 | 204 | 6. 5 | 33 | 1. 0 |
| Address unknown | 3, 204 | 2, 070 | 64. 6 | 978 | 30. 5 | 156 | 4. 9 |

NOTE.—Percentages may not add due to rounding.

Source: "Foreign Medical Graduates in the United States." AMA, 1970.

**Table 21.**—*Foreign medical graduates in the United States by State of practice and major professional activity, Dec. 31, 1970* [1]

| State | Total | Major professional activity | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Patient care | | | | Other professional activity | | | | | |
| | | | | Hospital based practice | | | | | | | |
| | | Total | Office based practice | Interns and residents | Full-time physician staff | Medical teaching | Admin-istration | Research | Other | Not classified | Inactive |
| Total | 57, 217 | 48, 191 | 20, 980 | 16, 648 | 10, 563 | 1, 006 | 1, 194 | 3, 285 | 466 | 276 | 1, 821 |
| Alabama | 147 | 116 | 40 | 34 | 42 | 7 | 1 | 14 | 2 | 0 | 7 |
| Alaska | 17 | 17 | 13 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Arizona | 282 | 253 | 98 | 107 | 48 | 3 | 2 | 8 | 2 | 0 | 14 |
| Arkansas | 25 | 24 | 3 | 13 | 8 | 1 | 0 | 0 | 0 | 0 | 0 |
| California | 2, 980 | 2, 264 | 1, 630 | 292 | 342 | 65 | 72 | 276 | 27 | 19 | 257 |
| Colorado | 259 | 178 | 69 | 56 | 53 | 9 | 13 | 43 | 0 | 1 | 15 |
| Connecticut | 1, 267 | 1, 109 | 494 | 448 | 167 | 18 | 24 | 64 | 8 | 6 | 38 |
| Delaware | 217 | 199 | 80 | 56 | 63 | 1 | 5 | 6 | 1 | 1 | 4 |
| District of Columbia | 778 | 630 | 169 | 324 | 137 | 24 | 37 | 62 | 11 | 4 | 10 |
| Florida | 1, 769 | 1, 429 | 700 | 384 | 345 | 29 | 28 | 78 | 28 | 3 | 174 |
| Georgia | 434 | 373 | 169 | 86 | 118 | 15 | 15 | 23 | 3 | 0 | 5 |
| Hawaii | 203 | 172 | 107 | 48 | 17 | 6 | 4 | 8 | 1 | 1 | 11 |
| Idaho | 11 | 10 | 5 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 1 |
| Illinois | 4, 542 | 4, 021 | 1, 803 | 1, 527 | 691 | 64 | 84 | 182 | 28 | 16 | 147 |
| Indiana | 473 | 420 | 275 | 70 | 75 | 10 | 8 | 19 | 4 | 2 | 10 |
| Iowa | 323 | 267 | 118 | 108 | 41 | 10 | 4 | 25 | 2 | 6 | 9 |
| Kansas | 299 | 239 | 63 | 96 | 80 | 7 | 10 | 28 | 6 | 4 | 5 |
| Kentucky | 346 | 281 | 81 | 86 | 114 | 14 | 11 | 22 | 6 | 6 | 6 |
| Louisiana | 261 | 200 | 23 | 107 | 70 | 20 | 2 | 29 | 2 | 3 | 5 |
| Maine | 174 | 153 | 113 | 4 | 36 | 2 | 8 | 2 | 3 | 1 | 5 |
| Maryland | 2, 249 | 1, 848 | 679 | 702 | 467 | 40 | 70 | 221 | 17 | 6 | 47 |
| Massachusetts | 1, 998 | 1, 524 | 405 | 719 | 400 | 33 | 41 | 308 | 11 | 40 | 41 |
| Michigan | 2, 376 | 2, 168 | 749 | 1, 049 | 370 | 37 | 30 | 80 | 14 | 7 | 40 |
| Minnesota | 645 | 523 | 187 | 243 | 93 | 17 | 9 | 76 | 3 | 2 | 15 |
| Mississippi | 67 | 50 | 21 | 13 | 16 | 2 | 4 | 6 | 1 | 0 | 4 |
| Missouri | 982 | 808 | 227 | 378 | 203 | 25 | 31 | 85 | 8 | 4 | 21 |
| Montana | 30 | 27 | 17 | 2 | 8 | 0 | 1 | 0 | 2 | 0 | 0 |
| Nebraska | 70 | 51 | 15 | 18 | 18 | 8 | 4 | 5 | 0 | 0 | 2 |

Footnotes at end of table.

Table 21.—*Foreign medical graduates in the United States by State of practice and major professional activity, Dec. 31, 1970*[1]—Con.

| State | Major professional activity | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Patient care | | | | Other professional activity | | | | | |
| | | | | Hospital based practice | | | | | | | |
| | Total | Total | Office based practice | Interns and residents | Full-time physician staff | Medical teaching | Admin-istration | Research | Other | Not classified | Inactive |
| Nevada | 14 | 11 | 5 | 2 | 4 | 1 | 1 | 0 | 0 | 0 | 1 |
| New Hampshire | 145 | 126 | 96 | 8 | 22 | 1 | 3 | 6 | 1 | 3 | 5 |
| New Jersey | 3, 224 | 2, 930 | 1, 291 | 982 | 657 | 39 | 54 | 72 | 27 | 11 | 91 |
| New Mexico | 127 | 105 | 53 | 25 | 27 | 2 | 4 | 9 | 0 | 0 | 7 |
| New York | 15, 946 | 13, 842 | 5, 979 | 4, 777 | 3, 086 | 225 | 341 | 812 | 118 | 77 | 531 |
| North Carolina | 311 | 222 | 69 | 77 | 76 | 5 | 16 | 54 | 1 | 1 | 12 |
| North Dakota | 91 | 84 | 60 | 5 | 19 | 1 | 1 | 2 | 1 | 1 | 1 |
| Ohio | 3, 516 | 3, 170 | 1, 323 | 1, 280 | 567 | 44 | 58 | 127 | 40 | 18 | 59 |
| Oklahoma | 105 | 74 | 19 | 19 | 36 | 7 | 3 | 18 | 0 | 0 | 3 |
| Oregon | 141 | 113 | 52 | 38 | 23 | 6 | 5 | 14 | 0 | 0 | 3 |
| Pennsylvania | 2, 710 | 2, 327 | 757 | 1, 117 | 453 | 64 | 44 | 184 | 20 | 17 | 54 |
| Rhode Island | 495 | 444 | 218 | 117 | 109 | 3 | 7 | 20 | 5 | 4 | 12 |
| South Carolina | 99 | 78 | 16 | 23 | 39 | 4 | 2 | 5 | 1 | 2 | 7 |
| South Dakota | 70 | 66 | 49 | 2 | 15 | 0 | 1 | 1 | 1 | 0 | 1 |
| Tennessee | 306 | 249 | 64 | 109 | 76 | 15 | 8 | 25 | 3 | 0 | 6 |
| Texas | 1, 540 | 1, 327 | 707 | 399 | 221 | 34 | 21 | 111 | 10 | 1 | 36 |
| Utah | 43 | 24 | 1 | 16 | 7 | 2 | 1 | 13 | 0 | 0 | 3 |
| Vermont | 71 | 61 | 35 | 12 | 14 | 1 | 1 | 5 | 1 | 0 | 2 |
| Virginia | 896 | 788 | 417 | 192 | 179 | 24 | 24 | 24 | 11 | 2 | 23 |
| Washington | 429 | 342 | 233 | 53 | 56 | 12 | 8 | 34 | 5 | 2 | 26 |
| West Virginia | 463 | 421 | 209 | 85 | 127 | 7 | 8 | 10 | 6 | 1 | 10 |
| Wisconsin | 642 | 546 | 269 | 160 | 117 | 12 | 10 | 39 | 14 | 3 | 18 |
| Wyoming | 13 | 13 | 10 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| Possessions | 1, 414 | 1, 293 | 663 | 169 | 460 | 29 | 38 | 30 | 6 | 1 | 17 |
| APO–FPO | 204 | 181 | 32 | 9 | 140 | 1 | 17 | 0 | 5 | 0 | 0 |
| Address unknown | 978 | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) |

Source: "Foreign Medical Graduates in the United States," AMA, 1970.

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[1] Excludes Canadian medical graduates in the United States.
[2] Not applicable.

Less than half of the FMG's in the United States were fully licensed to practice, in 1970. Table 22 outlines the licensure status of FMG's by State as of 1970.

TABLE 22.—*Foreign medical graduates in the United States by State of practice and licensure* [1] *Dec. 31, 1970*

| State | Total | Licensure | |
|---|---|---|---|
| | | Full license | Not licensed |
| Total | 57, 217 | 25, 178 | 30, 857 |
| Alabama | 147 | 29 | 118 |
| Alaska | 17 | 10 | 7 |
| Arizona | 282 | 131 | 151 |
| Arkansas | 25 | 3 | 22 |
| California | 2, 980 | 2, 073 | 907 |
| Colorado | 259 | 89 | 170 |
| Connecticut | 1, 267 | 603 | 664 |
| Delaware | 217 | 74 | 143 |
| District of Columbia | 778 | 198 | 580 |
| Florida | 1, 769 | 994 | 775 |
| Georgia | 434 | 199 | 235 |
| Hawaii | 203 | 114 | 89 |
| Idaho | 11 | 7 | 4 |
| Illinois | 4, 542 | 2, 348 | 2, 194 |
| Indiana | 473 | 256 | 217 |
| Iowa | 323 | 140 | 183 |
| Kansas | 299 | 83 | 216 |
| Kentucky | 346 | 64 | 282 |
| Louisiana | 261 | 16 | 245 |
| Maine | 174 | 148 | 26 |
| Maryland | 2, 249 | 912 | 1, 337 |
| Massachusetts | 1, 998 | 629 | 1, 369 |
| Michigan | 2, 376 | 565 | 1, 811 |
| Minnesota | 645 | 244 | 401 |
| Mississippi | 67 | 41 | 26 |
| Missouri | 982 | 276 | 706 |
| Montana | 30 | 16 | 14 |
| Nebraska | 70 | 23 | 47 |
| Nevada | 14 | 5 | 9 |
| New Hampshire | 145 | 37 | 108 |
| New Jersey | 3, 224 | 1, 232 | 1, 992 |
| New Mexico | 127 | 58 | 69 |
| New York | 15, 946 | 7, 480 | 8, 466 |
| North Carolina | 311 | 82 | 229 |
| North Dakota | 91 | 30 | 61 |
| Ohio | 3, 516 | 895 | 2, 621 |
| Oklahoma | 105 | 26 | 79 |
| Oregon | 141 | 67 | 74 |
| Pennsylvania | 2, 710 | 1, 251 | 1, 459 |
| Rhode Island | 495 | 286 | 209 |
| South Carolina | 99 | 25 | 74 |
| South Dakota | 70 | 56 | 14 |
| Tennessee | 306 | 95 | 211 |
| Texas | 1, 540 | 932 | 608 |
| Utah | 43 | 5 | 38 |
| Vermont | 71 | 32 | 39 |
| Virginia | 896 | 512 | 384 |
| Washington | 429 | 304 | 125 |
| West Virginia | 463 | 104 | 359 |
| Wisconsin | 642 | 343 | 299 |
| Wyoming | 13 | 7 | 6 |
| Possessions | 1, 414 | 1, 029 | 385 |
| APO–FPO | 204 | (2) | (2) |
| Address unknown | 978 | (2) | (2) |

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[1] Excludes Canadian medical graduates in the United States.

[2] Not applicable.

Source: "Foreign Medical Graduates in the United States." AMA, 1970.

## C. UNDERGRADUATE MEDICAL EDUCATION

By the fall of 1974, there were 114 medical schools in the United States. Ninety-eight were fully accredited 4-year schools of medicine; three were accredited schools of basic medical sciences; and four were developing medical schools, with students enrolled and provisional approval but not yet eligible for full approval. Table 23 lists the 114 medical schools with enrolled students during academic year 1974–75 and their locations, type of ownership, year of organization, resident and nonresident tuition, and the numbers of students enrolled and graduated.

## Table 23.—*Approved medical schools and schools of basic medical science*

| State | Number | Medical schools | Ownership | Year organized | Tuition (estimate) 1976–77 |  | Students, 1974–75 |  |  | Graduates, July 1, 1974 to June 30, 1975 |
|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  |  |  | Resident | Nonresident | 1st year | Other years | Total |  |
| Alabama | 1 | University of Alabama School of Medicine, Birmingham. | Public | 1859 | 1, 600 | 3, 200 | 127 | 137 | 498 | 234 |
| Arizona | 2 | University of Arizona College of Medicine, Tucson | do | 1967 | 1, 050 | 2, 040 | 75 | 107 | 280 | 98 |
| Arkansas | 3 | University of Arkansas School of Medicine, Little Rock. | do | 1879 | 850 | 1, 700 | 122 | 241 | 468 | 105 |
| California | 4 | University of California School of Medicine, Davis | do | 1968 | 670 | 2, 170 | 100 | 208 | 404 | 96 |
|  | 5 | University of California College of Medicine, Irvine | do | 1962 | 892 | 2, 392 | 70 | 155 | 289 | 64 |
|  | 6 | Loma Linda University School of Medicine, Loma Linda. | Private | 1909 | 4, 000 | 4, 000 | 160 | 332 | 627 | 135 |
|  | 7 | University of California School of Medicine, Los Angeles. | Public | 1951 | [1] 681 | [1] 2, 181 | 147 | 318 | 604 | 139 |
|  | 8 | University of Southern California School of Medicine, Los Angeles. | Private | 1885 | 3, 250 | 3, 250 | 130 | 244 | 472 | 98 |
|  | 9 | Stanford University School of Medicine, Palo Alto | do | 1908 | 4, 242 | 4, 242 | 94 | 215 | 390 | 81 |
|  | 10 | University of California School of Medicine, San Diego. | Public | 1968 | 700 | 2, 200 | 96 | 130 | 275 | 49 |
|  | 11 | University of California School of Medicine, San Francisco. | do | 1864 | 720 | 2, 220 | 149 | 303 | 575 | 123 |
| Colorado | 12 | University of Colorado School of Medicine, Denver | do | 1883 | 1, 296 | 4, 808 | 129 | 264 | 521 | 128 |
| Connecticut | 13 | University of Connecticut School of Medicine, Farmington. | do | 1968 | 950 | 1, 850 | 64 | 125 | 226 | 37 |
|  | 14 | Yale University School of Medicine, New Haven | Private | 1812 | 4, 100 | 4, 100 | 102 | 217 | 419 | 100 |
| District of Columbia | 15 | Georgetown University of Medicine | do | 1851 | 5, 000 | 5, 000 | 208 | 403 | 811 | 200 |
|  | 16 | George Washington University School of Medicine | do | 1825 | 5, 500 | 5, 500 | 151 | 298 | 591 | 142 |
|  | 17 | Howard University College of Medicine | Private | 1868 | 1, 500 | 1, 500 | 137 | 233 | 479 | 109 |
| Florida | 18 | University of Florida College of Medicine, Gainesville. | Public | 1956 | [2] 281 | [2] 631 | 111 | 197 | 382 | 74 |
|  | 19 | University of Miami School of Medicine, Miami | Private | 1952 | 2, 700 | 2, 700 | 132 | 287 | 564 | 145 |
|  | 20 | University of South Florida College of Medicine, Tampa. | Public | 1965 | 1, 084 | 2, 484 | 65 | 32 | 145 | 48 |
| Georgia | 21 | Emory University School of Medicine, Atlanta | Private | 1854 | 3, 100 | 3, 100 | 105 | 220 | 423 | 98 |
|  | 22 | Medical College of Georgia, Augusta | Public | 1828 | 960 | 1, 860 | 180 | 328 | 653 | 145 |
| Hawaii | 23 | University of Hawaii School of Medicine, Honolulu | do | 1967 | 700 | 1, 750 | 69 | 140 | 271 | 62 |
| Illinois | 24 | Chicago Medical School University of Health Sciences, Chicago. | Private | 1912 | 6, 000 | 6, 000 | 107 | 179 | 381 | 95 |
|  | 25 | Northwestern University Medical School, Chicago | do | 1859 | 3, 480 | 3, 480 | 173 | 354 | 684 | 157 |
|  | 26 | Loyola University of Chicago Stritch School of Medicine, Maywood. | do | 1915 | 1, 050 | 1, 050 | 136 | 259 | 522 | 127 |
|  | 27 | Rush Medical College, Chicago | do | 1969 | [2] 1, 200 | [2] 1, 200 | 90 | 115 | 286 | 81 |
|  | 28 | Southern Illinois University School of Medicine, Springfield. | Public | 1969 | [3] 900 | [3] 2, 150 | 60 | 44 | 128 | 24 |
|  | 29 | University of Chicago Pritzker School of Medicine, Chicago. | Private | 1927 | 3, 420 | 3, 420 | 106 | 243 | 454 | 105 |
|  | 30 | University of Illinois, College of Medicine, Chicago | Public | 1881 | 1, 125 | 1, 125 | 341 | 588 | 1, 159 | 230 |
| Indiana | 31 | Indiana University School of Medicine, Indianapolis. | do | 1903 | 1, 050 | 2, 200 | 310 | 599 | 1, 169 | 260 |

Footnotes at end of table.

Table 23.—*Approved medical schools and schools of basic medical science*—Continued

| State | Number | Medical schools | Ownership | Year organized | Tuition (estimate) 1976–77 |  | Students, 1974–75 |  |  | Graduates, July 1, 1974 to June 30, 1975 |
|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  |  |  | Resident | Nonresident | 1st year | Other years | Total |  |
| Iowa | 32 | University of Iowa College of Medicine, Iowa City. | Public | 1850 | 1, 200 | 2, 500 | 179 | 338 | 663 | 146 |
| Kansas | 33 | University of Kansas School of Medicine, Kansas City. | do | 1905 | 1, 025 | 2, 025 | 168 | 172 | 568 | 228 |
| Kentucky | 34 | University of Kentucky College of Medicine, Lexington. | do | 1954 | 910 | 1, 805 | 111 | 204 | 413 | 98 |
|  | 35 | University of Louisville School of Medicine, Louisville. | Private | 1837 | 1, 225 | 2, 150 | 138 | 269 | 530 | 123 |
| Louisiana | 36 | Louisiana State University School of Medicine, New Orleans. | Public | 1931 | 800 | 2, 300 | 149 | 295 | 587 | 143 |
|  | 37 | Tulane University School of Medicine, New Orleans. | Private | 1834 | 3, 500 | 3, 500 | 151 | 298 | 593 | 144 |
|  | 38 | Louisiana State University School of Medicine, Shreveport. | Public | 1966 | 800 | 2, 300 | 42 | 48 | 167 | 41 |
| Maryland | 39 | Johns Hopkins University School of Medicine, Baltimore. | Private | 1893 | 3, 300 | 3, 300 | 122 | 243 | 481 | 116 |
|  | 40 | University of Maryland School of Medicine, Baltimore. | Public | 1807 | 1, 200 | 1, 200 | 169 | 319 | 621 | 133 |
| Massachusetts | 41 | Boston University School of Medicine, Boston | Private | 1873 | 4, 900 | 4, 900 | 140 | 259 | 505 | 106 |
|  | 42 | Harvard Medical School, Boston | do | 1783 | 3, 500 | 3, 500 | 165 | 340 | 668 | 163 |
|  | 43 | Tufts University School of Medicine, Boston | do | 1893 | 3, 950 | 3, 950 | 152 | 299 | 605 | 154 |
|  | 44 | University of Massachusetts Medical School, Worcester. | Public | 1962 | 600 |  | 66 | 66 | 154 | 22 |
| Michigan | 45 | University of Michigan Medical School, Ann Arbor | do | 1850 | 1, 600 | 3, 200 | 249 | 476 | 955 | 230 |
|  | 46 | Wayne State University School of Medicine, Detroit. | do | 1885 | 1, 554 | 3, 180 | 265 | 496 | 968 | 207 |
|  | 47 | Michigan State University College of Human Medicine, East Lansing. | do | 1966 | 816 | 1, 836 | 111 | 201 | 384 | 72 |
| Minnesota | 48 | University of Minnesota Medical School, Minneapolis. | do | 1883 | 2, 094 | 4, 636 | 253 | 514 | 1, 006 | 239 |
| Mississippi | 49 | University of Mississippi School of Medicine, Jackson. | do | 1903 | 856 | 1, 456 | 154 | 236 | 491 | 101 |
| Missouri | 50 | University of Missouri School of Medicine, Columbia. | do | 1840 | 730 | 1, 810 | 112 | 217 | 434 | 105 |
|  | 51 | University of Missouri School of Medicine, Kansas City. | do | 1968 | [4] 726 | [4] 1, 944 | 73 | 70 | 165 | 22 |
|  | 52 | St. Louis University School of Medicine, St. Louis. | Private | 1903 | 3, 500 | 3, 500 | 156 | 302 | 602 | 144 |
|  | 53 | Washington University School of Medicine, St. Louis. | do | 1899 | 3, 450 | 3, 450 | 126 | 291 | 544 | 127 |
| Nebraska | 54 | Creighton University School of Medicine, Omaha | do | 1892 | 3, 800 | 3, 800 | 112 | 219 | 439 | 108 |
|  | 55 | University of Nebraska College of Medicine, Omaha. | Public | 1881 | 960 | 1, 920 | 159 | 159 | 537 | 219 |
| New Hampshire | 56 | Dartmouth Medical School, Hanover | Private | 1797 | 5, 000 | 5, 000 | 67 | 63 | 161 | 31 |
| New Jersey | 57 | CMDNJ—New Jersey Medical School, Newark | Public | 1956 | 1, 100 | 1, 750 | 120 | 241 | 473 | 112 |
|  | 58 | CMDNJ—Rutgers Medical School, Piscataway | do | 1966 | 1, 750 | 3, 000 | 108 | 148 | 290 | 34 |
| New Mexico | 59 | University of New Mexico School of Medicine, Albuquerque. | do | 1960 | 630 | 1, 500 | 75 | 134 | 267 | 58 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| New York | 60 | Albany Medical College of Union University, Albany. | Private | 1839 | 3, 300 | 3, 300 | 108 | 224 | 426 | 94 |
| | 61 | State University of New York at Buffalo School of Medicine. | Public | 1846 | 1, 652 | 2, 052 | 136 | 276 | 540 | 128 |
| | 62 | Columbia University College of Physicians and Surgeons, New York. | Private | 1767 | 3, 750 | 3, 750 | 148 | 307 | 586 | 131 |
| | 63 | Cornell University Medical College, New York | do | 1898 | 4, 000 | 4, 000 | 103 | 212 | 413 | 98 |
| | 64 | Albert Einstein College of Medicine of Yeshiva University, New York. | do | 1955 | 3, 750 | 3, 750 | 188 | 194 | 580 | 203 |
| | 65 | Mt. Sinai School of Medicine of the City University of New York. | do | 1968 | 4, 000 | 4, 000 | 81 | 140 | 282 | 61 |
| | 66 | New York Medical College, New York | do | 1860 | 3, 450 | 3, 450 | 330 | 196 | 802 | 276 |
| | 67 | New York University School of Medicine, New York. | do | 1841 | 3, 800 | 3, 800 | 177 | 331 | 398 | 147 |
| | 68 | State University of New York College of Medicine, Brooklyn. | Public | 1860 | 1, 600 | 2, 000 | 226 | 442 | 880 | 212 |
| | 69 | University of Rochester School of Medicine and Dentistry, Rochester. | Private | 1920 | 3, 275 | 3, 275 | 97 | 208 | 398 | 93 |
| | 70 | State University of New York at Stony Brook School of Medicine. | Public | 1962 | 1, 600 | 2, 000 | 49 | 43 | 115 | 23 |
| | 71 | State University of New York College of Medicine, Syracuse. | do | 1834 | 1, 600 | 2, 000 | 124 | 238 | 480 | 118 |
| North Carolina | 72 | University of North Carolina School of Medicine, Chapel Hill. | do | 1879 | 872 | 2, 502 | 131 | 260 | 498 | 107 |
| | 73 | Duke University School of Medicine, Durham | Private | 1930 | 3, 400 | 3, 400 | 120 | 255 | 479 | 104 |
| | 74 | Bowman Gray School of Medicine, Winston-Salem | do | 1902 | 3, 000 | 3, 000 | 90 | 180 | 348 | 78 |
| Ohio | 75 | University of Cincinnati College of Medicine, Cincinnati. | Public | 1819 | [5]1, 350 | 2, 700 | 200 | 243 | 559 | 116 |
| | 76 | Case Western Reserve University School of Medicine, Cleveland. | Private | 1843 | 3, 000 | 3, 000 | 147 | 292 | 570 | 131 |
| | 77 | Ohio State University College of Medicine, Columbus. | Public | 1914 | 1, 240 | 2, 640 | 239 | 263 | 729 | 227 |
| | 78 | Medical College of Ohio at Toledo | do | 1964 | 1, 800 | 2, 500 | 81 | 71 | 199 | 47 |
| Oklahoma | 79 | University of Oklahoma School of Medicine, Oklahoma City. | do | 1900 | 749 | 1, 669 | 159 | 297 | 593 | 137 |
| Oregon | 80 | University of Oregon Medical School, Portland | do | 1887 | 1, 000 | 2, 200 | 115 | 233 | 440 | 92 |
| Pennsylvania | 81 | Pennsylvania State University College of Medicine, the Milton S. Hershey Medical Center, Hershey. | Private | 1967 | 1, 500 | 3, 000 | 96 | 168 | 329 | 65 |
| | 82 | Hahnemann Medical College and Hospital, Philadelphia. | do | 1848 | 3, 600 | 3, 600 | 175 | 330 | 629 | 124 |
| | 83 | Jefferson Medical College of Thomas Jefferson University, Philadelphia. | do | 1824 | 3, 250 | 3, 250 | 232 | 441 | 892 | 219 |
| | 84 | Medical College of Pennsylvania (Formerly Women's), Philadelphia. | do | 1850 | 3, 600 | 3, 600 | 93 | 181 | 363 | 89 |
| | 85 | Temple University School of Medicine, Philadelphia. | do | 1901 | 1, 500 | 3, 000 | 186 | 360 | 718 | 172 |
| | 86 | University of Pennsylvania School of Medicine, Philadelphia. | do | 1765 | 3, 800 | 3, 800 | 160 | 322 | 656 | 174 |
| | 87 | University of Pittsburgh School of Medicine, Pittsburgh. | do | 1883 | 1, 500 | 3, 000 | 140 | 260 | 516 | 116 |
| Puerto Rico | 88 | University of Puerto Rico School of Medicine, San Juan. | Public | 1949 | 570 | 570 | 118 | 232 | 454 | 104 |
| Rhode Island | 89 | Brown University Program in Medical Science, Providence. | Private | 1963 | 3, 500 | 3, 500 | 62 | 118 | 238 | 58 |
| South Carolina | 90 | Medical University of South Carolina College of Medicine, Charleston. | Public | 1823 | 1,000 | 1,840 | 165 | 332 | 645 | 148 |

Footnotes at end of table.

TABLE 23.—*Approved medical schools and schools of basic medical science*—Continued

| State | Number | Medical schools | Ownership | Year organized | Tuition (estimate) 1976–77 |  | Students, 1974–75 |  |  | Graduates, July 1, 1974 to June 30, 1975 |
|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  |  |  | Resident | Nonresident | 1st year | Other years | Total |  |
| Tennessee | 91 | University of Tennessee College of Medicine, Memphis. | Public | 1851 | [6] 1,364 | [6] 2,836 | 205 | 320 | 716 | 191 |
|  | 92 | Meharry Medical College School of Medicine, Nashville. | Private | 1876 | 2,500 | 2,500 | 120 | 219 | 425 | 86 |
|  | 93 | Vanderbilt University School of Medicine, Nashville. | do | 1873 | 3,300 | 3,300 | 83 | 171 | 327 | 73 |
| Texas | 94 | University of Texas Southwestern Medical School, Dallas. | Public | 1943 | 300 | 900 | 202 | 292 | 627 | 133 |
|  | 95 | University of Texas Medical Branch, Galveston | do | 1887 | 400 | 1,200 | 209 | 354 | 735 | 172 |
|  | 96 | Baylor College of Medicine, Houston | Private | 1900 | 400 | 2,800 | 168 | 280 | 581 | 133 |
|  | 97 | University of Texas Medical School, Houston | Public | 1969 | 300 | 900 | 52 | 57 | 151 | 42 |
|  | 98 | Texas Tech University School of Medicine, Lubbock. | do | 1969 | 400 | 1,200 | 45 | 45 | 131 | 41 |
|  | 99 | University of Texas Medical School, San Antonio | do | 1968 | 400 | 1,200 | 122 | 244 | 476 | 110 |
| Utah | 100 | University of Utah College of Medicine, Salt Lake City. | do | 1905 | 850 | 1,540 | 101 | 201 | 399 | 97 |
| Vermont | 101 | University of Vermont College of Medicine, Burlington. | do | 1833 | 1,545 | 3,365 | 83 | 168 | 321 | 70 |
| Virginia | 102 | University of Virginia School of Medicine, Charlottesville. | do | 1825 | 1,164 | 2,464 | 133 | 238 | 477 | 106 |
|  | 103 | Medical College of Virginia, Richmond | do | 1838 | 1,400 | 2,800 | 168 | 273 | 578 | 137 |
| Washington | 104 | University of Washington School of Medicine, Seattle. | do | 1945 | 1,120 | 2,452 | 136 | 265 | 502 | 101 |
| West Virginia | 105 | West Virginia University School of Medicine, Morgantown. | do | 1902 | 472 | 1,308 | 84 | 169 | 335 | 82 |
| Wisconsin | 106 | University of Wisconsin Medical School, Madison | do | 1907 | 1,500 | 3,325 | 161 | 307 | 588 | 120 |
|  | 107 | Medical College of Wisconsin, Milwaukee | Private | 1913 | 1,500 | 3,150 | 122 | 251 | 486 | 113 |
| Subtotal |  |  |  |  |  |  | 14,603 | 25,971 | 53,288 | 12,714 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | ACCREDITED SCHOOLS OF BASIC MEDICAL SCIENCES | | | | | | | | |
| Nevada | 108 | University of Nevada School of Medical Sciences, Reno. | Public | 1967 | 2, 000 | 7, 000 | 49 | 47 | 96 | 0 |
| North Dakota | 109 | University of North Dakota School of Medicine, Grand Forks.[6] | do | 1905 | 605 | 1, 455 | 68 | 105 | 173 | 0 |
| South Dakota | 110 | University of South Dakota School of Medicine, Vermillian.[6] | do | 1907 | 1, 139 | 2, 523 | 65 | 63 | 128 | 0 |
| Subtotal | | | | | | | 182 | 215 | 397 | 0 |
| | | DEVELOPING MEDICAL SCHOOLS—OPERATIONAL (PROVISIONAL APPROVAL, NOT YET ELIGIBLE FOR FULL APPROVAL) | | | | | | | | |
| Alabama | 111 | University of So. Alabama College of Medicine, Mobile. | Public | 1967 | 1, 293[1] | 1, 293[1] | 64 | 89 | 153 | 0 |
| Minnesota | 112 | Mayo Medical School, Rochester | Private | 1971 | 2, 300 | 3, 500 | 41 | 79 | 120 | 0 |
| | 113 | University of Minnesota School of Medicine, Duluth. | Public | 1972 | 2, 000 | 4, 000 | 36 | 23 | 59 | 0 |
| Virginia | 114 | Eastern Virginia Medical School, Norfolk | Private | 1973 | 3, 500 | 4, 500 | 37 | 20 | 57 | 0 |
| Subtotal | | | | | | | 178 | 211 | 389 | |
| Grand total | | | | | | | 14, 963 | 26, 397 | 54, 074 | 12, 714 |

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[1] For three quarters.
[2] Per quarter.
[3] For 12 months.
[4] For 48 weeks.
[5] For residents of Cincinnati, $1,200.
[6] In transition to M.D. degree-granting institution.

Source: Estimated tuition listed in the Association of American Medical College's "Medical School Admission Requirements 1976–77, United States and Canada."

Source: Journal of the American Medical Association, Dec. 2. 1975, vol. 234.

In addition to the 114 U.S. schools with students enrolled, there are several schools in various stages of planning and development.

Table 24 outlines proposed medical schools (no students enrolled), fall of 1975.

TABLE 24.—*Proposed medical schools (no students enrolled), fall 1975*

| School | Tentative starting date | Maximum 1st-year enrollment planned |
|---|---|---|
| East Carolina Universiry School of Medicine, Greenville, N.C. | January 1977 | 40 |
| East Tennessee State University School of Medicine, Johnson City, Tenn. | Fall 1978 | 72 |
| Marshall University School of Medicine, Huntington, W. Va. | Fall 1977 | 72 |
| Mercer University School of Medicine, Macon, Ga. | (1) | 60 |
| Morehouse College Medical Education Program, Atlanta. | Fall 1977 | 100 |
| American Indian School, Northern Arizona University, Ariz. | (1) | (1) |
| Northeastern Ohio Universities College of Medicine, Kent, Ohio. | Fall 1977 | 100 |
| University of South Carolina Medical School, Columbia, S.C. [2] | Fall 1976 | 112 |
| Texas A. & M. University/Baylor College of Medicine, College Station, Tex. | Fall 1977 | 96 |
| Medical School of the University of Health Sciences of the Uniformed Services, Bethesda, Md | (1) | 125 |
| Wright State University, School of Medicine, Dayton, Ohio [2] | Fall 1976 | 96 |

[1] As yet unknown.
[2] These schools have letters of assurance from the LCME.

Source: Journal of the American Medical Association. Dec. 29, 1975, vol. 234, No. 13.

There were 36,336 full-time faculty members reported teaching in medical schools during the 1974–75 academic year. This represents less than a 10-percent increase over the number of faculty reported for 1972–73.

The medical student-faculty ratio had decreased from 1.6 in 1967–68 to 1.4 in 1972–73 but rose to 1.5 for the past two years.

Table 25 compares faculty data for the past 8 academic years—with respect to the number of medical students and the total number of students for which medical faculty is responsible.

TABLE 25.—*Number of full-time faculty, medical students, and total student equivalents in U.S. medical schools*

| | 1967–68 | 1968–69 | 1969–70 | 1970–71 | 1971–72 | 1972–73 | 1973–74 [1] | 1974–75 [2] |
|---|---|---|---|---|---|---|---|---|
| Full-time faculty | 22,163.0 | 23,014.0 | 24,706.0 | [3] 26,504.0 | [3] 29,469.0 | [3] 33,550.0 | 33,172.0 | 36,336.0 |
| Medical students | 34,538.0 | 35,833.0 | 37,669.0 | 40,487.0 | 43,650.0 | 47,546.0 | 49,808.0 | 53,143.0 |
| Medical student-faculty ratio | 1.6 | 1.6 | 1.5 | 1.5 | 1.5 | 1.4 | 1.5 | 1.5 |
| Total student equivalents | 86,319.0 | 91,046.0 | 92,678.0 | 98,012.0 | 109,984.0 | 118,587.0 | 119,568.0 | 142,238.0 |
| Total students-equivalents-faculty ratio | 3.9 | 4.0 | 3.7 | 3.7 | 3.7 | 3.5 | 3.6 | 3.9 |

[1] Yale did not report faculty, Harvard did not report students; both schools are excluded.
[2] Arkansas and Cincinnati did not report faculty; both schools are excluded.
[3] Harvard did not provide figures for 1970–71; Missouri-Kansas City and Nevada did not provide figures in 1972–73.

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

Of the 36,336 faculty members in the 1974–75 academic year, 9,047 were professors, 7,925 were associate professors, 12,445 were assistant professors, and 6,144 were instructors. The number of budgeted but vacant full-time faculty positions reported was 2,173, or 5.6 percent of the total budgeted positions.

Table 26 presents data on budgeted but unfilled full-time faculty positions for academic years 1966–67 through 1974–75, while table 27 shows actual figures for budgeted (filled and unfilled) positions by department for academic year 1974–75.

TABLE 26.—*Budgeted unfilled full-time faculty positions in medical schools, 1966–67 to 1974–75*

| Department | 1966–67 | 1967–68 | 1968–69 | 1969–70[1] | 1970–71 | 1971–72[2] | 1972–73 | 1973–74 | 1974–75 |
|---|---|---|---|---|---|---|---|---|---|
| Basic sciences anatomy | 76 | 79 | 93 | 80 | 76 | 81 | 95 | 98 | 112 |
| Biochemistry | 90 | 92 | 92 | 73 | 64 | 58 | 66 | 52 | 46 |
| Microbiology | 82 | 82 | 77 | 70 | 71 | 50 | 75 | 87 | 83 |
| Pathology | 108 | 129 | 124 | 113 | 125 | 141 | 135 | 172 | 159 |
| Pharmacology | 58 | 79 | 57 | 70 | 56 | 53 | 65 | 77 | 83 |
| Physiology | 73 | 96 | 87 | 83 | 82 | 66 | 75 | 93 | 72 |
| Other | 33 | 13 | 49 | 52 | 34 | 47 | 63 | 22 | 49 |
| Subtotal | 520 | 570 | 579 | 541 | 508 | 496 | 575 | 601 | 609 |
| Clinical anesthesiology | 60 | 60 | 70 | 81 | 98 | 99 | 96 | 125 | 107 |
| Dermatology | 8 | 8 | 7 | 8 | 7 | 11 | 15 | 15 | 15 |
| Family medicine | | | | | | | 71 | 102 | 108 |
| Medicine | 138 | 164 | 233 | 228 | 184 | 219 | 259 | 288 | 346 |
| Neurology | 37 | 43 | 45 | 34 | 25 | 42 | 41 | 55 | 62 |
| Obstetrics-gynecology | 67 | 71 | 82 | 98 | 67 | 83 | 87 | 100 | 118 |
| Ophthalmology | 17 | 22 | 18 | 25 | 23 | 35 | 37 | 34 | 29 |
| Orthopedics | 20 | 23 | 25 | 30 | 31 | 30 | 28 | 37 | 34 |
| Otolaryngology | 19 | 12 | 21 | 18 | 14 | 28 | 23 | 24 | 28 |
| Pediatrics | 83 | 100 | 102 | 76 | 78 | 114 | 114 | 136 | 142 |
| Physical medicine | 21 | 30 | 33 | 29 | 19 | 20 | 26 | 31 | 29 |
| Psychiatry | 95 | 128 | 131 | 104 | 89 | 103 | 97 | 121 | 133 |
| Public health and preventive medicine | 65 | 90 | 73 | 67 | 55 | 44 | 44 | 69 | 51 |
| Radiology | 78 | 110 | 94 | 105 | 114 | 117 | 85 | 110 | 135 |
| Surgery | 87 | 95 | 118 | 132 | 104 | 160 | 147 | 182 | 169 |
| Urology | 17 | 15 | 12 | 17 | 14 | 12 | 35 | 48 | 27 |
| Other | 42 | 40 | 48 | 41 | 60 | 124 | 66 | 15 | 31 |
| Subtotal | 854 | 1, 015 | 1, 112 | 1, 093 | 982 | 1, 241 | 1, 271 | 1, 492 | 1, 504 |
| Total | 1, 374 | 1, 585 | 1, 691 | 1, 584 | 1, 490 | 1, 737 | 1, 846 | 2, 093 | 2, 113 |

[1] Minnesota did not provide information.

[2] Missouri-KC and Nevada did not provide information.

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 27.—*Percentage of budget (filled and unfilled) positions vacant, by department, in medical schools* [1]

| Department | Full-time faculty, number | Positions unfilled, number | Total budgeted positions, number | Positions unfilled, percent |
|---|---|---|---|---|
| Basic science: | | | | |
| Anatomy | 1,522 | 111 | 1,633 | 6.7 |
| Biochemistry | 1,440 | 46 | 1,486 | 3.1 |
| Microbiology | 1,224 | 83 | 1,307 | 6.4 |
| Pathology | 2,456 | 159 | 2,615 | 6.1 |
| Pharmacology | 1,194 | 88 | 1,282 | 6.9 |
| Physiology | 1,359 | 72 | 1,431 | 5.0 |
| Other basic sciences | 861 | 49 | 910 | 5.4 |
| Subtotal | 10,056 | 608 | 10,664 | 5.7 |
| Clinical science: | | | | |
| Anesthesiology | 1,376 | 107 | 1,483 | 7.2 |
| Dermatology | 262 | 15 | 277 | 5.4 |
| Family medicine | 550 | 108 | 658 | 16.4 |
| Medicine | 6,630 | 346 | 9,976 | 5.0 |
| Neurology | 1,022 | 62 | 1,084 | 5.7 |
| Obstetrics-gynecology | 1,305 | 118 | 1,423 | 8.3 |
| Opthalmology | 531 | 29 | 560 | 5.2 |
| Orthopedics | 373 | 34 | 407 | 8.3 |
| Otolaryngology | 430 | 28 | 458 | 6.1 |
| Pediatrics | 2,970 | 142 | 3,112 | 4.6 |
| Physical medicine | 459 | 29 | 488 | 5.9 |
| Psychiatry | 3,580 | 133 | 3,713 | 3.6 |
| Public health and preventive medicine | 1,103 | 51 | 1,154 | 4.4 |
| Radiology | 2,275 | 135 | 2,410 | 5.6 |
| Surgery | 2,579 | 169 | 2,748 | 6.2 |
| Urology | 235 | 27 | 262 | 10.3 |
| Other clinical departments | 600 | 31 | 631 | 4.9 |
| Subtotal | 26,280 | 1,564 | 27,844 | 5.6 |
| Total | 36,336 | 2,172 | 38,508 | 5.6 |

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[1] Arkansas and Cincinnati did not report faculty; Columbia University did not breakout total by ranks.

Source: Journal of the American Medical Association. Dec. 29, 1975, vol. 234, No. 13.

The medical student population can be characterized by the number of applicants, enrollment, student attrition, and utilization of student financial resources.

Applicants to medical schools totaled 42,624 for academic year 1974–75. The number of applicants accepted was 15,066 or 35 percent of the total number of applicants to medical schools. The number of students applying for admission into medical schools in the United States has increased 122 percent in the past 10 years. The number of applicants for the 1964–65 entering class was 19,168. The applicants/acceptance ratio has steadily increased since the 1960–61 academic year—from 1.7 in that year to 2.8 in 1974–75—indicating that the number of individuals applying to medical schools is growing at a faster rate than the number of individuals accepted for enrollment in medical schools.

Table 28 summarizes medical school application activities for the past 22 academic years.

TABLE 28.—*Summary of application activity during the past 22 years*

| 1st-year class | Applicants [1] | Total number of applications [1] | Applications per individual [1] | Accepted applicants [1] | Applicants/acceptance ratio [1] | 1st-year enrollment |
|---|---|---|---|---|---|---|
| 1953–54 | 14, 678 | 48, 586 | 3. 3 | 7, 756 | 1. 9 | 7, 449 |
| 1954–55 | 14, 538 | 46, 568 | 3. 3 | 7, 878 | 1. 8 | 7, 576 |
| 1955–56 | 14, 937 | 54, 161 | 3. 6 | 7, 969 | 1. 9 | 7, 686 |
| 1956–57 | 15, 917 | 59, 798 | 3. 8 | 8, 263 | 1. 9 | 8, 014 |
| 1957–58 | 15, 791 | 60, 951 | 3. 9 | 8, 302 | 1. 9 | 8, 030 |
| 1958–59 | 15, 170 | 59, 102 | 2. 9 | 8, 366 | 1. 8 | 8, 128 |
| 1959–60 | 14, 952 | 57, 888 | 2. 9 | 8, 512 | 1. 8 | 8, 173 |
| 1960–61 | 14, 397 | 54, 662 | 3. 8 | 8, 550 | 1. 7 | 8, 298 |
| 1961–62 | 14, 381 | 53, 834 | 3. 7 | 8, 682 | 1. 7 | 8, 483 |
| 1962–63 | 15, 847 | 59, 054 | 3. 7 | 8, 959 | 1. 8 | 8, 642 |
| 1963–64 | 17, 668 | 70, 063 | 4. 0 | 9, 063 | 1. 9 | 8, 772 |
| 1964–65 | 19, 168 | 84, 578 | 4. 4 | 9, 043 | 2. 1 | 8, 856 |
| 1965–66 | 18, 703 | 87, 111 | 4. 7 | 9, 012 | 2. 1 | 8, 759 |
| 1966–67 | 18, 250 | 87, 627 | 4. 8 | 9, 123 | 2. 0 | 8, 964 |
| 1967–68 | 18, 724 | 93, 332 | 5. 0 | 9, 702 | 1. 9 | 9, 479 |
| 1968–69 | 21, 117 | 112, 195 | 5. 3 | 10, 092 | 2. 1 | 9, 863 |
| 1969–70 | 24, 465 | 134, 557 | 5. 5 | 10, 514 | 2. 3 | 10, 401 |
| 1970–71 | 24, 985 | 148, 797 | 6. 0 | 11, 500 | 2. 2 | 11, 348 |
| 1971–72 | 29, 172 | 210, 943 | 7. 2 | 12, 335 | 2. 4 | 12, 361 |
| 1972–73 | 36, 135 | 267, 306 | 7. 4 | 13, 757 | 2. 6 | 13, 726 |
| 1973–74 | 40, 506 | 328, 275 | 8. 1 | 14, 335 | 2. 8 | 14, 185 |
| 1974–75 | 42, 624 | 362, 376 | 8. 5 | 15, 066 | 2. 8 | 14, 963 |

[1] From the study of applicants, Association of American Medical Colleges.

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

In 1930–31, there were 76 medical schools; by 1972–73, there were 112; today there are 114. Total enrollments grew from 21,982 in 1931–32 to 54,074 in 1974–75. The number of graduates increased from 4,735 to 12,714.

Table 29 presents data on the number of medical schools, students, and graduates, 1930–31 through 1974–75.

TABLE 29.—*Students and graduates in the medical and basic science schools, 1930–75*

| Year | Number of schools [1] | Total enrollment | 1st year | Intermediate years | Graduates |
|---|---|---|---|---|---|
| 1930–31 | 76 | 21, 982 | 6, 456 | 10, 791 | 4, 735 |
| 1935–36 | 77 | 22, 564 | 6, 605 | 10, 776 | 5, 183 |
| 1940–41 | 77 | 21, 379 | 5, 837 | 10, 267 | 5, 275 |
| 1945–46 | 77 | 23, 216 | 6, 060 | 11, 330 | 5, 826 |
| 1950–51 | 79 | 26, 186 | 7, 177 | 12, 874 | 6, 135 |
| 1955–56 | 82 | 28, 639 | 6, 686 | 14, 108 | 6, 845 |
| 1956–57 | 85 | 29, 130 | 8, 014 | 14, 320 | 6, 796 |
| 1957–58 | 85 | 29, 476 | 8, 030 | 14, 582 | 6, 861 |
| 1958–59 | 85 | 28, 614 | 8, 128 | 14, 626 | 6, 860 |
| 1959–60 | 85 | 30, 084 | 8, 173 | 14, 830 | 7, 081 |
| 1960–61 | 86 | 30, 288 | 8, 298 | 14, 996 | 6, 994 |
| 1961–62 | 87 | 31, 078 | 8, 483 | 15, 427 | 7, 163 |
| 1962–63 | 87 | 31, 491 | 8, 642 | 15, 595 | 7, 264 |
| 1963–64 | 87 | 32, 001 | 8, 772 | 15, 893 | 7, 386 |
| 1964–65 | 88 | 32, 428 | 8, 856 | 16, 163 | 7, 409 |
| 1965–66 | 88 | 32, 835 | 8, 759 | 16, 562 | 7, 574 |
| 1966–67 | 89 | 33, 423 | 8, 964 | 16, 716 | 7, 743 |
| 1967–68 | 94 | 34, 536 | 9, 479 | 17, 086 | 7, 973 |
| 1968–69 | 99 | 35, 833 | 9, 863 | 17, 911 | 8, 059 |
| 1969–70 | 101 | 37, 669 | 10, 401 | 18, 901 | 8, 367 |
| 1970–71 | 103 | 40, 487 | 11, 348 | 20, 165 | 8, 974 |
| 1971–72 | 108 | 46, 650 | 12, 361 | 21, 733 | 9, 551 |
| 1972–73 | 112 | 47, 546 | 13, 726 | 23, 429 | 10, 391 |
| 1973–74 | 114 | 50, 886 | 14, 185 | 25, 088 | 11, 613 |
| 1974–75 | 114 | 54, 074 | 14, 963 | 26, 397 | 12, 714 |

[1] Prior to 1956–57, schools in development were not included.

Source: Journal of the American Medical Association Dec. 29, 1975, vol. 234, No. 13.

Table 30 outlines the number of new first-year students and number of M.D. graduates projected by 114 medical schools, spring 1975. The number of students accepted with advanced standing from other graduate programs or from foreign medical schools was not taken into account by these projections.

TABLE 30.—*Number of new first-year students and number of M.D. graduates projected by 114 medical schools (spring 1975)*

| Year | 1st-year class | M.D. graduates |
|---|---|---|
| 1975–76 | 14, 874 | 13, 505 |
| 1976–77 | 15, 262 | 13, 818 |
| 1977–78 | 15, 516 | 14, 452 |
| 1978–79 | 15, 821 | 14, 849 |
| 1979–80 | 15, 946 | 14, 999 |

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

In 1974–75, 984 medical students (or 1.83 percent of total medical school enrollments) were not promoted with their class. This figure includes students who withdrew or were dismissed for academic reasons, those who withdrew to pursue advanced study, and those who withdrew or were dismissed for other reasons. When the 984 total is reduced by the number of students withdrawing to pursue advanced studies, the attrition drops to 1.50 percent.

The net attrition rate, which is defined as the percentage of students withdrawing entirely from the pursuit of an M.D. degree, is only 1.31 percent of the total enrollment for 1974–75. Academic reasons were given in less than half of these dropout cases.

Tables 31 and 32 present data on student attrition rates in medical schools for academic year 1974–75.

TABLE 31.—*Net attrition rate in medical schools, 1974–75* [1]

| Class year | Enrollment | Attrition [2] | |
|---|---|---|---|
| | | Number | Percent |
| 1st | 14, 870 | 314 | 2. 11 |
| Intermediate | 26, 216 | 337 | 1. 28 |
| Final | 12, 625 | 52 | . 41 |
| Total | 53, 711 | 703 | 1. 31 |

[1] Does not include Medical College of Pennsylvania.

[2] Excluded are students who transferred to another medical school or who withdrew to pursue advanced studies.

Source: Journal of the American Medical Association. Dec. 29, 1975, Vol. 234, No. 13.

TABLE 32.—*Number of students who withdrew or were dismissed, 1974–75* [1]

| Class year | Total enrollment | Reason for withdrawal | | | Total withdrawals |
|---|---|---|---|---|---|
| | | Poor academic record | Advanced study | Other | |
| 1st | 14, 870 | 133 | 2 | 199 | 334 |
| Intermediate | 26, 216 | 100 | 156 | 322 | 578 |
| Final | 12, 625 | 11 | 19 | 42 | 72 |
| Total | 53, 711 | 244 | 177 | 563 | 984 |

[1] Medical College of Pennsylvania, which did not report medical student attrition is not included.

Enrollments and graduations of minority students in U.S. medical schools have increased in recent years. In 1972–73, blacks, Mexican Americans, American Indians, and mainland Puerto Ricans comprised about 6.6 percent of total medical school enrollments. In 1974–75, the percentage increased to 8.1. First-year enrollments increased from 8 percent in 1972–73 to 8.8 percent in 1974–75. Graduates in these categories increased from 3.9 to 6.3 percent. Tables 33 and 34 present data on minorities in U.S. medical schools.

TABLE 33.—*Percentage minority enrollment in U.S. medical schools, 1972–73 and 1974–75*

| | 1972–73 | | 1974–75 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| 1st-year enrollment: [1] | | | | |
| Afro-American | 858 | 6. 4 | 950 | 6. 5 |
| Mexican American | 151 | 1. 1 | 199 | 1. 4 |
| American Indian | 33 | . 2 | 70 | . 5 |
| Puerto Rican (mainland) [2] | 44 | . 3 | 63 | . 4 |
| 4 group total | 1, 086 | 8. 0 | 1, 282 | 8. 8 |
| Graduates: | | | | |
| Afro-American | 341 | 3. 3 | 638 | 5. 0 |
| Mexican American | 39 | . 4 | 110 | . 9 |
| American Indian | 8 | . 1 | 22 | . 2 |
| Puerto Rican (mainland) [2] | 10 | . 1 | 28 | . 2 |
| 4 group total | 398 | 3. 9 | 798 | 6. 3 |
| Total enrollment: | | | | |
| Afro-American | 2, 593 | 5. 5 | 3, 396 | 6. 3 |
| Mexican American | 380 | . 8 | 638 | 1. 2 |
| American Indian | 68 | . 1 | 161 | . 3 |
| Puerto Rican (mainland) [2] | 98 | . 2 | 168 | . 3 |
| 4 group total | 3, 139 | 6. 6 | 4, 363 | 8. 1 |

[1] 1st-year enrollment data excluded repeaters.

[2] University of Puerto Rico is excluded.

Source: Journal of the American Medical Association. Dec. 29, 1975. Vol. 234, No. 13.

TABLE 34.—*Minority student information by individual U.S. medical schools*

| Medical school | Minority enrollment, fall of 1973 [1] |  |  |  | Minority faculty and administration [2] |  |  |
|---|---|---|---|---|---|---|---|
|  | Black American | American Indian | Mexican American | Mainland Puerto Rican | Basic science | Clinical science | Administration |
| Grand total [3] | 3,041/1,019 | 96/44 | 496/174 | [4] 122/55 |  |  |  |
| Alabama | 26/10 | 0/0 | 0/0 | 0/0 |  |  |  |
| Alabama, South | 3/2 | 0/0 | 0/0 | 0/0 | 0 | 1 | 0 |
| Albany | 4/4 | 0/0 | 0/0 | 0/0 | 2 | 6 | 0 |
| Arizona | 2/1 | 3/2 | 11/7 | 0/0 | 0 | 0 | 1 |
| Arkansas | 13/6 | 0/0 | 0/0 | 0/0 | 0 | 2 | 0 |
| Baylor | 21/12 | 1/0 | 29/12 | 0/0 | 2 | 25 | 0 |
| Boston University | 29/12 | 0/0 | 1/1 | 8/4 | 0 | 14 | 1 |
| Bowman Gray | 15/9 | 0/0 | 0/0 | 0/0 | 2 | 2 | 0 |
| Brown [5] | 2/1 | 0/0 | 0/0 | 0/0 | 0 | 1 | 1 |
| California: |  |  |  |  |  |  |  |
| Davis | 20/7 | 0/0 | 27/10 | 0/0 | 2 | 3 | 0 |
| Irvine | 11/9 | 4/3 | 10/5 | 2/2 |  |  |  |
| Los Angeles | 28/5 | 0/0 | 38/10 | 2/2 |  |  |  |
| San Diego | 18/2 | 2/0 | 26/5 | 1/0 | 4 | 11 | 1 |
| San Francisco | 67/18 | 3/2 | 42/11 | 1/1 | 7 | 10 | 1 |
| California, Southern | 24/6 | 1/0 | 28/8 | 0/0 | – | – | – |
| Case Western Reserve | 59/19 | 0/0 | 2/0 | 1/0 | 4 | 24 | 2 |
| Chicago, Medical | 10/7 | 0/0 | 0/0 | 0/0 | 7 | 13 | 2 |
| Chicago, University of | 23/2 | 1/1 | 2/0 | 0/0 | 1 | 1 | 0 |
| Cincinnati | 29/10 | 0/0 | 0/0 | 0/0 | 3 | 29 | 0 |
| Colorado | 21/7 | 7/3 | 23/8 | 0/0 | 0 | 6 | 0 |
| Columbia | 51/15 | 0/0 | 0/0 | 7/1 | 0 | [6] 325 | 2 |
| Connecticut | 10/7 | 0/0 | 0/0 | 1/0 | – | – | – |
| Cornell | 32/11 | 0/0 | 0/0 | 8/2 | – | – | – |
| Creighton | 13/1 | 1/0 | 0/0 | 0/0 | 1 | 4 | 2 |
| Dartmouth | 4/2 | 5/3 | 2/2 | 0/0 | 1 | 0 | 0 |
| Duke | 24/6 | 1/1 | 0/0 | 2/2 | 1 | 4 | 0 |
| Einstein | 13/2 | 0/0 | 0/0 | 4/1 |  |  |  |
| Emory | 16/6 | 0/0 | 0/0 | 0/0 | 0 | 32 | 1 |
| Florida (including Florida State) | 37/12 | 0/0 | 0/0 | 0/0 | 1 | 1 | 0 |
| Florida, South | 2/1 | 0/0 | 0/0 | 0/0 | 0 | 0 | 0 |
| Georgetown | 26/8 | 0/0 | 0/0 | 0/0 | 11 | 46 | 0 |
| George Washington | 15/6 | 0/0 | 0/0 | 0/0 | 0 | 47 | 0 |
| Georgia | 30/10 | 0/0 | 0/0 | 0/0 | 0 | 2 | 0 |
| Hahnemann | 37/10 | 1/1 | 0/0 | 2/1 | 1 | 4 | 1 |
| Harvard | 72/21 | 4/0 | 11/5 | 5/4 |  |  |  |
| Hawaii | 0/0 | 1/1 | 0/0 | 0/0 |  |  |  |
| Howard | 326/94 | 0/0 | 0/0 | 0/0 |  | [7] 624 | 6 |
| Illinois | 81/30 | 1/1 | 12/4 | 2/2 | 3 | 14 | 6 |
| Illinois, Southern | 3/2 | 0/0 | 0/0 | 0/0 | 2 | 2 | 0 |
| Indiana | 36/15 | 0/0 | 1/1 | 1/1 | 3 | 17 | 1 |
| Iowa | 18/8 | 0/0 | 0/0 | 0/0 | 1 | 1 | 1 |
| Jefferson | 34/10 | 0/0 | 0/0 | 4/1 | 2 | 10 | 0 |
| Johns Hopkins | 27/3 | 0/0 | 4/0 | 0/0 |  |  |  |
| Kansas | 21/9 | 3/1 | 3/1 | 0/0 |  |  |  |
| Kentucky | 5/2 | 0/0 | 0/0 | 0/0 | 0 | 2 | 1 |
| Loma Linda | 12/1 | 1/0 | 2/0 | 3/0 | 0 | 15 | 0 |
| Louisiana: |  |  |  |  |  |  |  |
| New Orleans | 18/5 | 0/0 | 0/0 | 0/0 |  |  |  |
| Shreveport | 2/0 | 0/0 | 0/0 | 0/0 | 1 | 2 | 0 |
| Louisville | 12/6 | 0/0 | 0/0 | 2/0 | 1 | 10 | 0 |
| Loyola Stritch | 27/7 | 2/0 | 0/0 | 0/0 |  |  |  |
| Maryland | 39/16 | 2/0 | 0/0 | 0/0 | 4 | 30 | 1 |
| Massachusetts | 0/0 | 0/0 | 0/0 | 0/0 | 0 | 1 | 0 |
| Mayo | 3/2 | 0/0 | 0/0 | 0/0 | 1 | 1 | 0 |
| Meharry | 341/98 | 0/0 | 2/2 | 0/0 | 25 | 56 | 30 |
| Miami | 8/3 | 0/0 | 0/0 | 0/0 | 1 | 6 | 0 |
| Michigan State | 34/8 | 1/1 | 11/8 | 0/0 | 5 | 4 | 1 |
| Michigan, University of | 103/30 | 1/0 | 4/2 | 3/3 | 4 | 8 | 2 |
| Minnesota: |  |  |  |  |  |  |  |
| Duluth [8] | 0/0 | 4/2 | 0/0 | 0/0 | 0 | 0 | 1 |
| Minneapolis | 35/16 | 4/1 | 9/6 | 2/0 |  |  |  |

Footnotes at end of table.

TABLE 34.—*Minority student information by individual U.S. medical schools*—Continued

| Medical school | Minority enrollment, fall of 1973 [1] | | | | Minority faculty and administration [2] | | |
|---|---|---|---|---|---|---|---|
| | Black American | American Indian | Mexican American | Mainland Puerto Rican | Basic science | Clinical science | Administration |
| Mississippi | 19/9 | 0/0 | 0/0 | 0/0 | 0 | 2 | 1 |
| Missouri: | | | | | | | |
| Columbia | 14/9 | 1/1 | 0/0 | 0/0 | 0 | 1 | 0 |
| Kansas City | 5/1 | 0/0 | 1/0 | 0/0 | 0 | 0 | 2 |
| Mount Sinai | 10/6 | 0/0 | 0/0 | 5/1 | --- | --- | --- |
| Nebraska | 4/2 | 2/2 | 1/0 | 1/0 | 0 | 1 | 4 |
| Nevada [8] | 1/0 | 0/0 | 0/0 | 0/0 | 1 | 0 | 0 |
| New Jersey Medical | 61/25 | 0/0 | 0/0 | 7/4 | --- | --- | --- |
| New Mexico | 2/0 | 5/3 | 40/14 | 1/1 | 2 | 4 | 1 |
| New York Medical | 11/4 | 0/0 | 0/0 | 8/6 | 2 | 22 | 4 |
| New York: SUNY: | | | | | | | |
| Buffalo | 68/24 | 1/0 | 1/1 | 9/2 | 1 | 14 | 1 |
| Downstate | 36/11 | 0/0 | 0/0 | 3/0 | 0 | 46 | 1 |
| Stony Brook | 9/4 | 0/0 | 0/0 | 1/1 | 2 | 3 | 1 |
| Upstate | 18/8 | 0/0 | 0/0 | 1/1 | 2 | 4 | 1 |
| New York University | 22/5 | 0/0 | 0/0 | 4/1 | 12 | 10 | 1 |
| North Carolina (including East Carolina) | 41/12 | 1/1 | 0/0 | 0/0 | 0 | 4 | 2 |
| North Dakota | 0/0 | 4/3 | 0/0 | 0/0 | --- | --- | --- |
| Northwestern | 26/7 | 0/0 | 0/0 | 0/0 | --- | --- | --- |
| Ohio, Medical College of | 11/2 | 0/0 | 3/1 | 0/0 | --- | --- | --- |
| Ohio State | 24/14 | 0/0 | 0/0 | 0/0 | 5 | 11 | 1 |
| Oklahoma | 4/2 | 7/2 | 9/6 | 0/0 | --- | --- | 0 |
| Oregon | 2/1 | 2/1 | 1/0 | 0/0 | 0 | 0 | 1 |
| Pennsylvania, Medical College of | 7/1 | 2/0 | 0/0 | 0/0 | 1 | 7 | 0 |
| Pennsylvania State | 21/5 | 0/0 | 1/0 | 0/0 | 2 | 1 | 2 |
| Pennsylvania, University of | 38/11 | 0/0 | 0/0 | 0/0 | --- | --- | --- |
| Pittsburgh | 46/14 | 0/0 | 0/0 | 0/0 | 1 | 14 | 0 |
| Puerto Rico | 0/0 | 0/0 | 0/0 | [9] 395/105 | 39 | 174 | 103 |
| Rochester | 19/5 | 0/0 | 0/0 | 1/0 | 1 | 16 | 1 |
| Rush | 24/8 | 0/0 | 1/1 | 1/1 | 1 | 8 | 1 |
| Rutgers | 27/12 | 0/0 | 1/1 | 6/3 | [7] 9 | | 2 |
| Saint Louis | 36/9 | 0/0 | 3/0 | 1/0 | 2 | 15 | 0 |
| South Carolina | 19/9 | 0/0 | 0/0 | 0/0 | 2 | 2 | 2 |
| South Dakota [5] | 0/0 | 0/0 | 0/0 | 0/0 | 0 | 0 | 0 |
| Stanford | 20/4 | 3/1 | 27/7 | 0/0 | 0 | 5 | 3 |
| Temple | 53/23 | 2/2 | 3/1 | 7/5 | 2 | 13 | 1 |
| Tennessee | 12/9 | 0/0 | 0/0 | 0/0 | --- | --- | --- |
| Texas: | | | | | | | |
| Galveston | 12/4 | 1/0 | 12/3 | 0/0 | 3 | 5 | 0 |
| Houston | 6/2 | 0/0 | 2/1 | 0/0 | 1 | 6 | 1 |
| San Antonio | 8/0 | 1/0 | 31/3 | 0/0 | 2 | 15 | 2 |
| Southwestern | 7/3 | 0/0 | 28/11 | 0/0 | 14 | 16 | 2 |
| Texas Tech | 4/4 | 0/0 | 3/2 | 0/0 | 0 | 2 | 5 |
| Tufts | 43/12 | 0/0 | 0/0 | 3/2 | 1 | 4 | 0 |
| Tulane | 25/14 | 1/1 | 1/0 | 0/0 | 0 | 9 | 0 |
| Utah | 2/0 | 3/1 | 16/7 | 0/0 | 2 | 7 | 0 |
| Vanderbilt | 6/3 | 0/0 | 0/0 | 0/0 | --- | --- | --- |
| Vermont | 1/1 | 1/1 | 0/0 | 0/0 | 1 | 0 | 1 |
| Virginia, Eastern | 2/2 | 0/0 | 0/0 | 0/0 | 1 | 1 | 1 |
| Virginia, Medical College of | 26/15 | 1/0 | 0/0 | 0/0 | 0 | 4 | 0 |
| Virginia, University of | 13/4 | 0/0 | 0/0 | 0/0 | --- | --- | --- |
| Washington—St. Louis | 38/16 | 0/0 | 1/1 | 0/0 | --- | --- | --- |
| Washington, University of | 18/4 | 2/0 | 7/4 | 0/0 | 2 | 5 | 0 |
| Wayne State | 53/17 | 1/1 | 0/0 | 0/0 | 1 | 17 | 0 |
| West Virginia | 5/2 | 0/0 | 1/1 | 0/0 | 0 | 0 | 0 |

Footnotes at end of table.

TABLE 34.—*Minority student information by individual U.S. medical schools*—Continued

| Medical school | Minority enrollment, fall of 1973 [1] Black American | American Indian | Mexican American | Mainland Puerto Rican | Minority faculty and administration [2] Basic science | Clinical science | Administration |
|---|---|---|---|---|---|---|---|
| Wisconsin, Medical College of | 6/2 | 0/0 | 0/0 | 1/0 | 2 | 9 | 0 |
| Wisconsin, University of | 21/10 | 0/0 | 2/1 | 0/0 | | | |
| Yale | 43/14 | 1/1 | 0/0 | 1/0 | 2 | 24 | 1 |

[1] The 1st figure under each category is the total number of minority students in the student body; the 2d figure is the number of minority students in the 1973–74 first-year class. Source of the data is the AAMC fall 1973 enrollment questionnaire.
[2] Source is the AAMC questionnaire on information for this publication. Part-time faculty included.
[3] Minority enrollment figures do not include March 1974 entering class at Loma Linda University.
[4] Totals do not include students enrolled at the University of Puerto Rico.
[5] In process of establishing a full M.D. degree program.
[6] Includes faculty members at affiliated teaching hospitals, particularly at the Harlem Hospital Center.
[7] Faculty not listed by area of responsibility.
[8] 2-year basic science school.
[9] Most, if not all, of these students are residents of Puerto Rico.

Note: No entry in column indicates information not available.

Source: "Medical School Admission Requirements 1975–76," Association of American Medical Colleges 1974.

In 1974–75, women represented almost 18.1 percent of total enrollments in medical schools, 37.5 percent of the first-year class, and 13.4 percent of the graduates. The number of women entering medical school represents a 360 percent increase over the number entering just four years ago. Table 35 summarizes application activities enrollments and graduations of women in U.S. medical schools for the past 35 years.

TABLE 35.—*Women in U.S. medical schools (selected years from 1939 to 1975)*

| Academic year | Women applicants [1] | | Women in entering class | | Total women enrolled | | Women graduates | |
|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| 1939–40 | 632 | 5. 4 | [2] 296 | 5. 0 | 1, 145 | 5. 4 | 253 | 5. 0 |
| 1949–50 | 1, 390 | 5. 7 | 387 | 5. 5 | 1, 806 | 7. 2 | 595 | 10. 7 |
| 1959–60 | 1, 026 | 6. 9 | 494 | 6. 0 | 1, 710 | 5. 7 | 405 | 5. 7 |
| 1964–65 | 1, 731 | 9. 0 | 786 | 8. 9 | 2, 503 | 7. 7 | 503 | 6. 8 |
| 1969–70 | 2, 289 | 9. 4 | 952 | 9. 2 | 3, 390 | 9. 0 | 700 | 8. 4 |
| 1970–71 | 2, 734 | 10. 9 | 1, 256 | 11. 1 | 3, 894 | 9. 6 | 827 | 9. 2 |
| 1971–72 | 3, 737 | 12. 8 | 1, 693 | 13. 7 | 4, 755 | 10. 9 | 860 | 9. 0 |
| 1972–73 | 5, 480 | 15. 2 | 2, 315 | 16. 9 | 6, 099 | 12. 8 | 924 | 8. 9 |
| 1973–74 | 7, 202 | 17. 8 | 2, 743 | 19. 6 | [3] 7, 731 | [3] 15. 4 | 1, 264 | 11. 1 |
| 1974–75 | 8, 712 | 20. 4 | 3, 260 | 22. 3 | 9, 786 | 18. 1 | 1, 706 | 13. 4 |

[1] From the study of applicants, Association of American Medical Colleges.

[2] Potthoff, E. F.: "The Future Supply of Medical Students in the U.S." (table 1). 35:224, 1960.

[3] Harvard did not provide enrollment figures.

Source: Journal of the American Medical Association, Dec. 29, 1975. Vol. 234, No. 13.

During the 1974–75 academic year, an estimated 110 foreign students were enrolled in first-year classes in 45 U.S. medical schools. Table 36 outlines data on foreign students in U.S. medical schools, 1951 through 1975.

TABLE 36.—*Number of foreign students in U.S. medical schools*

| Academic year | Number of foreign students | Number of U.S. medical schools accepting foreign students |
|---|---|---|
| 1951–52 through 1962–63 (total) | 1, 231 | 80 |
| 1st-year classes only: | | |
| 1963–64 | 108 | 43 |
| 1964–65 | 86 | 40 |
| 1965–66 | 123 | 38 |
| 1966–67 | 136 | 38 |
| 1967–68 | 151 | 48 |
| 1968–69 | 121 | 38 |
| 1969–70 | 170 | 40 |
| 1970–71 | 230 | 71 |
| 1971–72 | 239 | 67 |
| 1972–73 | 241 | 68 |
| 1973–74 | 217 | 72 |
| 1974–75 | [1] 110 | [1] 45 |

[1] Estimate.

Source: "Medical School Admissions Requirements, 1975–76," Association of American Medical College, 1974.

First-year expenses for medical students have increased considerably in recent years. In 1970–71, estimated first-year expenses for tuition and fees ranged from $1,068.50 to $2,620 at private medical schools. Tuition and fees at public schools ranged from $200 to $1,000 for residents and from $200 to $2,140 for nonresidents.

By 1975–76 the schools estimate that the same expenses will range from $1,200–$4,000 in private schools. In public schools such expenses will range from $300–$3,500 for residents and from $570–$4,500 for nonresidents.

Tables 37 and 38 compare estimated minimum expenses for first-year students at U.S. medical schools for the academic years 1970–71 and 1975–76.

TABLE 37.—*School estimates of minimum expenses for 1st-year students, 1970–71*

| Item | Private schools (N=46) |  | Public schools (N=56) |  |  |  |
|---|---|---|---|---|---|---|
|  |  |  | Resident |  | Nonresident |  |
|  | Range | Median | Range | Median | Range | Median |
| Tuition and fees [1] | $1, 068. 50–$2, 620 | $2, 000 | $200–$1, 000 | $682. 80 | $200–$2, 140 | $1, 300 |
| Room and board | 900. 00– 3, 000 | 1, 350 | 810– 2, 400 | 1, 200. 00 | 810– 2, 400 | 1, 200 |
| Books and supplies (not including microscopes) | 100. 00– 400 | 250 | 100– 480 | 250. 00 | 100– 480 | 250 |

[1] 3 private schools cite a lower tuition for residents. Some schools have a higher tuition for upper years. Note that some schools have additional fees.

Source: "Medical School Admission Requirements, 1969–70." Association of American Medical Colleges, 1969.

TABLE 38.—*Estimated minimum expenses for 1st year students at U.S. medical schools (1975–76)*[1]

| 1st-year expense item | Private schools [2] |  |  | Public schools |  |  |
|---|---|---|---|---|---|---|
|  | Range | Median | Average | Range | Median | Average |
| Tuition and fees: |  |  |  |  |  |  |
| Resident | $1, 200–$4, 000 | $3, 075 | $3, 139 | $300–$3, 500 | $960 | $1, 031 |
| Nonresident |  |  |  | 570– 4, 500 | 2, 060 | 2, 129 |
| Room and board (minimum) | 1, 080– 3, 500 | 2, 000 | 2, 086 | 940– 4, 000 | 1, 800 | 1, 898 |
| Books and supplies (not including microscope) | 180– 700 | 315 | 344 | 150– 1, 100 | 350 | 370 |

[1] Figures based on data provided fall 1973 by 45 private schools and 69 public schools.

[2] 4 private schools—Baylor, Mayo, Pittsburgh, and Rush—report lower tuition fees for residents than for nonresidents. The higher fees for these schools are used in the table.

Source: "Medical School Admission Requirements, 1975–76, "Association of American Medical Colleges, 1974.

During 1972–73, 36.0 percent of students enrolled in U.S. medical schools received a loan, while 28.6 percent received some financial support from scholarships. The average value of a loan was $1,695. The average value of a scholarship was $1,440. The amount of funds expended for loans and scholarships to medical students in academic year 1974–1975 totaled $52,879,604.

TABLE 39.—*Scholarships and loans administered by U.S. medical schools, 1973–74 and 1974–75* [1]

| | 1973–74 | | 1974–75 | |
|---|---|---|---|---|
| | Scholarships | Loans | Scholarships | Loans |
| Funds expended | $18, 927, 233 | $29, 772, 970 | $21, 321, 805 | $31, 557, 799 |
| Number of students | 15, 059 | 19, 251 | 14, 806 | 18, 615 |
| Average amount awarded | $1, 256 | $1, 546 | $1, 440 | $1, 695 |
| Percent of enrollment receiving awards | [2] 31. 0 | [2] 39. 7 | [2] 28. 6 | [2] 36. 0 |

[1] Data provided by 109 schools each year.

[2] Represents percentage of enrollment of the 109 reporting schools.

. Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

In the 1974–75 academic year, funds administered by the schools for scholarships and loans increased over the previous year. The average value of the scholarships and of the loans increased, although the number of students benefiting decreased. In 1973–74, 31 percent of the students enrolled in 109 reporting schools received scholarship funds, and 39.7 percent received loans.

In the 1974–75 academic year these percentages were down, with 28.6 percent of the enrollment receiving scholarships and 36 percent of the enrollment receiving loans.

During the 1974–75 year, bank guaranteed loans represented the major source of student financial aid, other than that disbursed by the school. 13,627 students (enrolled in the 109 reporting schools) received $28.3 million from this source during that year. The Armed Forces Health Professions Scholarships (HPS) ranked as the second largest source of aid not disbursed by the school with 2,549 students (enrolled in the 109 reporting schools) receiving $14.5 million aid from that source. The sources of loan funds given to medical students are shown in table 40. The sources of funds for scholarships awarded to medical students are shown in table 41.

TABLE 40.—*Sources of loan funds received by medical students, 1974–75* [1]

| Source | Amount | Number of loans | Average amount per loan |
|---|---|---|---|
| Administered by schools: | | | |
| Health professions loans | $21,315,978 | 14,264 | $1,494 |
| Robert Wood Johnson loans | 965,608 | 1,118 | 864 |
| Guaranteed loans | 2,397,533 | 1,358 | 1,765 |
| School funds | 5,974,815 | 5,759 | 1,037 |
| Other loans | 903,865 | 952 | 949 |
| Subtotal | 31,557,799 | 23,451 | 1,346 |
| Not administered by schools: | | | |
| AMA-ERF loans | 3,809,016 | 2,587 | 1,472 |
| Guaranteed loans | 28,302,608 | 13,627 | 2,077 |
| Other loans | 3,613,360 | 2,238 | 1,615 |
| Subtotal | 35,724,984 | 18,452 | 1,936 |
| Total loan funds | 67,282,783 | [2] 41,903 | 1,606 |

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[1] Includes data from 109 schools.

[2] This number represents the number of loans, not the number of individuals receiving loans.

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 41.—*Sources of scholarship funds received by medical students, 1974–75* [1]

| Source | Amount | Number of loans | Average amount per loan |
|---|---|---|---|
| Administered by schools: | | | |
| Health professions scholarships | $4,054,783 | 4,878 | $831 |
| Robert Wood Johnson Scholarships | 1,275,978 | 1,406 | 908 |
| School funds | 14,010,409 | 9,925 | 1,412 |
| Other | 1,890,635 | 1,083 | 1,746 |
| Subtotal | 21,231,805 | 17,292 | 1,228 |
| Not administered by schools: | | | |
| Armed Forces HPS | 14,744,033 | 2,549 | 5,784 |
| Public Health Service/HPS | 8,017,301 | 1,043 | 7,687 |
| Physician shortage area | 1,971,736 | 405 | 4,868 |
| National medical fellowships | 1,453,805 | 1,593 | 913 |
| Other | 4,646,159 | 3,206 | 1,449 |
| Subtotal | 30,833,034 | 8,796 | 3,505 |
| Total | 52,064,839 | [2] 26,088 | 1,996 |

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[1] Data provided by 109 schools.

[2] This number represents the number of awards, not the number of individuals receiving awards.

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

Medical schools spent $2.41 billion in 1973–74—an increase of $306,792 million over 1972–73. Federal funds accounted for $981,397,000 or 41 percent of the total funds expended.

TABLE 42.—*Medical financial support by source* [1]

[In thousands]

| Source | Amount 1958–59 | Amount 1972–73 | Amount 1973–74 |
|---|---|---|---|
| Federal funds: | | | |
| Contracts and grants for research (4) | $74, 128 | $472, 772 | $498, 310 |
| Contracts and grants for teaching (1) | 20, 772 | 236, 210 | 250, 181 |
| Grants and contracts for foreign teaching | | (2) | (2) |
| Sponsored multipurpose and service (10) | | 105, 663 | 95, 946 |
| Recovery of indirect costs on Federal contracts and grants (15) | | 131, 717 | 136, 960 |
| Subtotal | 94, 900 | 946, 362 | 981, 397 |
| Non-Federal grants and contracts for restricted programs: | | | |
| Contracts and grants for teaching and training (2) | 4, 660 | 41, 839 | 66, 525 |
| State, city, and county contracts gifts and grants for research (5) | 2, 855 | 11, 280 | 12, 725 |
| Nongovernment contracts gifts, and grants for research (6) | 33, 693 | 97, 320 | 107, 151 |
| Sponsored multipurpose and service (11) | | 203, 394 | 232, 242 |
| Recovery of indirect costs on non-Federal contracts and grants (16) | | 15, 273 | 16, 937 |
| Subtotal | 41, 208 | 369, 106 | 435, 580 |
| Internal funds: | | | |
| Tution and fees (14) | 24, 368 | 90, 538 | 105, 878 |
| Medical college expenses paid by teaching hospitals and clinics | 13, 727 | (2) | (2) |
| Medical college expenses paid by professional fee income (22) | 10, 636 | 146, 321 | 194, 414 |
| Income from college services (medical laboratories, etc.) (23) | 5, 260 | 54, 542 | 63, 112 |
| Other income (24) | 20, 228 | 58, 511 | 68, 835 |
| Endowment income restricted for research (7) | 3, 030 | 6, 306 | 6, 770 |
| Endowment income (18) | 17, 577 | 46, 952 | 41, 249 |
| Funding of net excess of expenditures over revenues (27) | 14, 478 | 19, 802 | 11, 505 |
| Subtotal | 109, 304 | 422, 972 | 491, 763 |
| Other sources of funds: | | | |
| State, city, and county grants-in-aid or subsidies, or payments via regional compacts such as WICHE (20) | 8, 166 | 33, 242 | 32, 408 |
| State appropriations (21) | 49, 779 | 316, 410 | 449, 597 |
| Gifts (19) | 10, 960 | 22, 335 | 26, 474 |
| Subtotal | 68, 905 | 371, 987 | 508, 479 |
| Total | [3] 319, 029 | 2, 110, 427 | 2, 417, 219 |

[1] Numbers in parentheses refer to line numbers in table 47.
[2] Part of combined items.
[3] Detail does not add to total because no Federal-non-Federal division in 2 categories.

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

Expenditures by fully activated 4-year medical schools ranged from about $3 million to $79.1 million in 1973–74. The average amount spent by a medical school in 1973–74 was approximately $23.6 million.

TABLE 43.—*Number of M.D. degree-granting accredited medical schools by size of total support*

| Magnitude of total support | 1972–73 | | 1973–74 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Under $10,000,000 | 9 | 10 | 19 | 19 |
| Over $10,000,000 and under $15,000,000 | 21 | 23 | 16 | 16 |
| Over $15,000,000 and under $20,000,000 | 14 | 16 | 14 | 14 |
| Over $20,000,000 and under $25,000,000 | 13 | 15 | 12 | 12 |
| Over $25,000,000 and under $30,000,000 | 11 | 12 | 11 | 11 |
| Over $30,000,000 and under $50,000,000 | 16 | 18 | 23 | 22 |
| $50,000,000 and over | 5 | 6 | 6 | 6 |
| Total | 89 | 100 | 101 | 100 |
| Support range: | | | | |
| Minimum support | $5, 725, 021 | | $3, 023, 070 | |
| Maximum support | 76, 920, 009 | | 79, 146, 565 | |
| Median support | 20, 027, 519 | | 20, 520, 801 | |
| Average support | 23, 556, 028 | | 23, 594, 779 | |

Source: Journal of American Medical Association, Dec. 29, 1975, Vol. 234, No. 13.

Sponsored support in medical schools can be defined as support provided for specific purposes under contracts, restricted gifts, or restricted grants by agencies or organizations interested in special medical school programs. The sponsors can be either public or private agencies and the funds must be used according to conditions set by the grantor.

General support in medical schools can be defined as those funds which are controlled by the medical school. These funds include all expenditures made by the schools for general educational purposes rather than for sponsored purposes.

Expenditures in individual 4-year medical school stemming from sponsored support ranged from approximately $500,000 to $61 million in 1973–1974. Total expenditures from sponsored support reached 1.3 billion.

Medical schools depend primarily on funds budgeted from general operating expenditures to meet their educational obligations. Support for general operating expenditures in medical schools ranged from about $1.6 million to $25 million in 1973–74.

Tables 44, 45 and 46 present data on sponsored and general support in medical schools.

TABLE 44.—*Changing pattern*[1] *of sponsored and total support in medical colleges, 1964–65 through 1973–74*

[Dollar amounts in thousands]

| Changes in amount spent for— | 1964–65 | 1965–66 | 1966–67 | 1967–68 | 1968–69 | 1969–70 | 1970–71 | 1971–72 | 1972–73 | 1973–74 | Average annual percent change 1965–74 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Total sponsored support | $459, 035 | $514, 206 | $581, 124 | $684, 341 | $790, 543 | $879, 355 | $933, 216 | $1, 058, 420 | $1, 174, 784 | $1, 269, 850 | +12 |
| 2. Sponsored research | 342, 901 | 375, 116 | 420, 232 | 473, 270 | 489, 314 | 489, 607 | 480, 979 | 550, 859 | 587, 678 | 624, 956 | +7 |
| 3. Federally sponsored research | 280, 562 | 307, 402 | 344, 480 | 389, 609 | 395, 814 | 381, 788 | 366, 006 | 440, 420 | 472, 772 | 498, 310 | +7 |
| 4. Nonfederally sponsored research | 62, 338 | 67, 715 | 75, 751 | 83, 661 | 93, 500 | 107, 819 | 114, 973 | 110, 439 | 114, 906 | 126, 646 | +8 |
| 5. Sponsored teaching and training programs | 104, 045 | 121, 153 | 138, 217 | 170, 820 | 184, 666 | 197, 703 | [1] 222, 952 | 254, 220 | 278, 049 | 316, 706 | +13 |
| 6. Federally sponsored teaching and training | 95, 731 | 110, 730 | 126, 672 | 154, 269 | 164, 099 | 171, 485 | [1] 194, 714 | 217, 980 | 236, 210 | 250, 181 | +11 |
| 7. Nonfederally sponsored teaching and training | 8, 314 | 10, 423 | 11, 545 | 16, 551 | 20, 567 | 26, 218 | 28, 624 | 36, 240 | 41, 839 | 66, 525 | +26 |
| 8. Other sponsored multipurpose and service | 12, 090 | 17, 937 | 22, 676 | 40, 251 | 116, 563 | 192, 045 | 228, 999 | 253, 341 | 309, 057 | 328, 188 | +44 |
| 9. Total financial support | 778, 700 | 882, 184 | 1, 010, 327 | 1, 175, 396 | 1, 366, 054 | 1, 549, 514 | 1, 712, 918 | 1, 942, 780 | 2, 110, 427 | 2, 417, 219 | +13 |
| Number of medical colleges reporting | 87 | 87 | 88 | 89 | 91 | 93 | 92 | 97 | 93 | 104 | |

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[1] These figures include expenditures of $386,000 from Federal grants and contracts for foreign teaching programs.

Note: As detailed in the opening section of this review, year-to-year changes may be misleading since not every school responded each year. Furthermore, data for developing schools are not included.

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 45.—*Number of M.D. degree-granting accredited medical schools by size of sponsored support*

| Magnitude of sponsored support | 1972–73 | | 1973–74 | |
|---|---|---|---|---|
| | Number of schools | Percent | Number of schools | Percent |
| Under $2,000,000 | 3 | 3 | 9 | 9 |
| Over $2,000,000 and under $4,000,000 | 6 | 7 | 8 | 8 |
| Over $4,000,000 and under $6,000,000 | 16 | 18 | 15 | 15 |
| Over $6,000,000 and under $8,000,000 | 10 | 11 | 9 | 9 |
| Over $8,000,000 and under $10,000,000 | 15 | 17 | 14 | 14 |
| Over $10,000,000 and under $15,000,000 | 14 | 16 | 19 | 18 |
| Over $15,000,000 and under $25,000,000 | 12 | 13 | 13 | 13 |
| $25,000,000 and over | 13 | 15 | 14 | 14 |
| Total | 89 | 100 | 101 | 100 |
| Support range: | | | | |
| Minimum support | $1, 571, 365 | | $520, 178 | |
| Maximum support | 59, 587, 709 | | 61, 052, 000 | |
| Median support | 9, 660, 300 | | 9, 270, 417 | |
| Average support | 13, 145, 871 | | 12, 513, 872 | |

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 46.—*Number of M.D. degree-granting accredited medical schools by amount of regular support for general operations*

| Magnitude of general operating support | 1972–73 | | 1973–74 | |
|---|---|---|---|---|
| | Number of schools | Percent | Number of schools | Percent |
| Under $2,000,000 | | | 2 | 2 |
| Over $2,000,000 and under $4,000,000 | 7 | 8 | 9 | 9 |
| Over $4,000,000 and under $6,000,000 | 13 | 15 | 12 | 12 |
| Over $6,000,000 and under $8,000,000 | 14 | 16 | 13 | 13 |
| Over $8,000,000 and under $10,000,000 | 16 | 18 | 15 | 14 |
| Over $10,000,000 and under $15,000,000 | 21 | 23 | 25 | 25 |
| $15,000,000 and over | 18 | 20 | 25 | 25 |
| Total | 89 | 100 | 101 | 100 |
| Support range: | | | | |
| Minimum support | $2, 753, 992 | | $1, 691, 893 | |
| Maximum support | 25, 275, 709 | | 24, 929, 904 | |
| Median support | 9, 218, 428 | | 9, 784, 764 | |
| Average support | 10, 182, 922 | | 11, 081, 006 | |

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

Table 47 summarizes data on expenditures by medical schools 1973–74. Schools reported total expenditures of $2,417,219,000.

TABLE 47.—*Summary of medical school financial support, 1973–74* [1]

| | Colleges using source (number) | Amount (thousands) |
|---|---|---|
| Sources of sponsored support: | | |
| 1. Federal contracts and grants for teaching and training | 104 | $250, 181 |
| 2. Non-Federal contracts and grants for teaching and training | 97 | 66, 525 |
| 3. Total of sponsored teaching and training contracts and grants (1 and 2) | 104 | (316, 706) |
| 4. Federal contracts and grants for research | 103 | 498, 310 |
| 5. State, city, and county contracts, gifts and grants for research | 75 | 12, 725 |
| 6. Nongovernment contracts, gifts, and grants for research | 102 | 107, 151 |
| 7. Endowment income restricted for research | 37 | 6, 770 |
| 8. Total non-Federal support for sponsored research (5 through 7) | 102 | (126, 646) |
| 9. Total support for sponsored and endowed research (4 plus 8) | 104 | (624, 956) |
| 10. Other Federal sponsored multipurpose and service | 86 | 95, 946 |
| 11. Other non-Federal sponsored multipurpose and service | 83 | 232, 242 |
| 12. Total support for sponsored multipurpose and service (10 plus 11) | 94 | (328, 188) |
| 13. Total sponsored support (3 plus 9 plus 12) | 104 | (1, 269, 850) |
| B. Sources of operating support: | | |
| 14. Tuition and fees | 100 | 105, 878 |
| 15. Recovery of indirect costs on Federal contracts and grants | 96 | 136, 960 |
| 16. Recovery of indirect costs on nonfederal contracts and grants | 84 | 16, 937 |
| 17. Total indirect cost recovery on contracts and grants (15 plus 16) | 96 | (153, 897) |
| 18. Endowment income | 64 | 41, 249 |
| 19. Gifts | 69 | 26, 474 |
| 20. State, city, and county grants-in-aid or subsidies to private schools or payments via interstate compacts such as WICHE | 35 | 32, 408 |
| 21. State appropriations | 66 | 449, 597 |
| 22. Professional fee (medical service plan) income | 69 | 194, 414 |
| 23. Income from college services | 62 | 63, 112 |
| 24. Other income | 77 | 68, 835 |
| 25. Total miscellaneous income (23 plus 24) | 90 | (131, 947) |
| 26. Total regular support | 104 | (1, 135, 864) |
| 27. Funding of net excess of expenditures over revenues [2] | 90 | 11, 505 |
| 28. Total operating support | 104 | (1, 147, 369) |
| 29. Total support (13 plus 28) | 104 | (2, 417, 219) |

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[1] Data as reported by 104 fully accredited schools of medicine and basic medical sciences in response to the 1973–74 LCME Financial Questionnaire. The following fully accredited institutions did not return a completed questionnaire in time to be included in the JAMA report: 1973–74—Baylor, Harvard, Hawaii, Howard, and Medical College of Virginia.

[2] A combination of general university funds, principal, or funds functioning as endowment, prior-year balances and/or reserves.

## D. OSTEOPATHIC UNDERGRADUATE EDUCATION

There were 1,032 first-year students in the colleges of osteopathic medicine in 1975. The 1975–76 enrollment in the nine osteopathic colleges reached 3,439. Of that number, 363 were women students. In 1975, osteopathic colleges graduated 695 doctors, 45, of which, were women. Based on the current enrollment in the nine osteopathic colleges, the projected number of graduates for 1976 is 827. Tables 48 through 50 present data on undergraduate osteopathic education.

TABLE 48.—*Enrollment, 1975–76*

| | 1st year students | 2d year students | 3d year students | 4th year students | Total |
|---|---|---|---|---|---|
| Total | 1, 032 | 959 | 878 | 570 | 3, 439 |

Source: Department of Educational Services, American Association of Colleges of Osteopathic Medicine, 1976.

TABLE 49.—*Enrollment, 1975–76*

| College | Total enrollment | | |
|---|---|---|---|
| | Men | Women | Total |
| Chicago College of Osteopathic Medicine | 349 | 31 | 380 |
| College of Osteopathic Medicine and Surgery [1] | 478 | 44 | 522 |
| Kansas City College of Osteopathic Medicine | 533 | 46 | 579 |
| Kirksville College of Osteopathic Medicine | 438 | 55 | 493 |
| Michigan State University College of Osteopathic Medicine [1] | 194 | 70 | 264 |
| Oklahoma College of Osteopathic Medicine and Surgery [1] | 85 | 7 | 92 |
| Philadelphia College of Osteopathic Medicine | 713 | 85 | 798 |
| Texas College of Osteopathic Medicine | 217 | 17 | 234 |
| West Virginia School of Osteopathic Medicine | 69 | 8 | 77 |
| Grand total | 3, 076 | 363 | 3, 439 |

[1] Denotes 3-year academic program.

Source: Department of Educational Services, American Association of Colleges of Osteopathic Medicine, 1976.

TABLE 50.—*Size of graduating classes, 1975*

| College | Graduates | | |
|---|---|---|---|
| | Men | Women | Total |
| Chicago College of Osteopathic Medicine | 82 | 3 | 85 |
| College of Osteopathic Medicine and Surgery [1] | 133 | 11 | 144 |
| Kansas City College of Osteopathic Medicine | 113 | 5 | 118 |
| Kirksville College of Osteopathic Medicine | 95 | 7 | 102 |
| Michigan State University College of Osteopathic Medicine [1] | 53 | 12 | 65 |
| Oklahoma College of Osteopathic Medicine and Surgery [1] | | | |
| Philadelphia College of Osteopathic Medicine | 150 | 6 | 156 |
| Texas College of Osteopathic Medicine | 24 | 1 | 25 |
| West Virginia School of Osteopathic Medicine | | | |
| Grand total | 650 | 45 | 695 |

[1] Denotes 3-year academic program.

Source: Department of Educational Services, American Association of Colleges of Osteopathic Medicine, 1976.

## E. GRADUATE MEDICAL EDUCATION

For academic year 1973–74, the number of hospitals offering internships decreased from the prior year as did the number of positions offered and filled.

The drop in the number of intership positions offered represented the second consecutive year of decline for those figures. The percentage of positions filled in 1973–74 increased, but the number of positions filled declined over 1972–73. The number of positions offered declined by 1,485 as compared with 1972–73; the number of positions filled declined by 132.

Tables 51 through 57 present data on internship programs—including the number of internships, number of internships by medical school affiliation and bed capacity, and salaries offered interns.

TABLE 51.—*Number of internships, 1964–73*

| | Number of hospitals | Number of internship positions offered | Number of internship positions filled | Percentage of positions filled |
|---|---|---|---|---|
| 1964–65 | 757 | 12, 728 | 10, 097 | 79 |
| 1965–66 | 772 | 12, 954 | 9, 670 | 75 |
| 1966–67 | 816 | 13, 569 | 10, 366 | 76 |
| 1967–68 | 853 | 13, 761 | 10, 419 | 76 |
| 1968–69 | 821 | 14, 112 | 10, 464 | 75 |
| 1969–70 | 900 | 15, 003 | 10, 808 | 72 |
| 1970–71 | 896 | 15, 354 | 11, 552 | 75 |
| 1971–72 | 797 | 15, 422 | 12, 066 | 78 |
| 1972–73 | 883 | 13, 650 | 11, 163 | 82 |
| 1973–74 | 741 | 12, 165 | 11, 031 | 91 |

Source: "Directory of Approved Internships and Residencies, 1974–75." AMA, 1975.

TABLE 52.—*Types of internship programs offered, 1964–73*

| Academic Year | Types of programs | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Rotating—no major emphasis | | Rotating with Emphasis on a specialty [1] | | Straight | | Family and general practice | | |
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | |
| 1964–65 | 658 | 50 | 189 | 14 | 467 | 35 | 14 | 1 | 1, 328 |
| 1965–66 | 641 | 45 | 251 | 17 | 531 | 37 | 17. | 1 | 1, 440 |
| 1966–67 | 568 | 24 | 1, 211 | 51 | 582 | 24 | 17 | 5 | 2, 378 |
| 1967–68 | 563 | 20 | 1, 502 | 54 | 687 | 25 | 16 | --------- | 2, 768 |
| 1968–69 | 581 | 21 | 1, 504 | 54 | 703 | 25 | --------- | --------- | 2, 788 |
| 1969–70 | 504 | 17 | 1, 675 | 57 | 714 | 25 | 29 | 1 | 2, 922 |
| 1970–71 | 523 | 17 | 1, 665 | 53 | 963 | 30 | --------- | --------- | 3, 151 |
| 1971–72 | 499 | 15 | 1, 737 | 53 | 1, 018 | 31 | --------- | --------- | 3, 254 |
| 1972–73 | 459 | 15 | 1, 562 | 54 | 892 | 31 | --------- | --------- | 2, 912 |
| 1973–74 | 421 | 19 | 948 | 43 | 835 | 38 | --------- | --------- | 2, 204 |

[1] Listed in tables previous to 1966–67 as "mixed" internships.

Source: "Directory of Approved Internships and Residencies, 1974–75," AMA, 1975.

TABLE 53.—*Number of internships by medical school affiliation and bed capacity*

| Classification | Number of hospitals | Number of approved programs | Number of internships |  |  | Per-centage filled | Number of interns on duty |  |  | Total flexible positions offered, 1975–76 |
|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  | Total positions offered Sept. 1, 1973 | Total positions filled Sept. 1, 1973 | Positions vacant Sept. 1, 1973 |  | Graduates, United States, Canada Sept. 1, 1973 | Foreign graduates Sept. 1, 1973 | Percentage foreign graduates in filled positions |  |
| Affiliated: |  |  |  |  |  |  |  |  |  |  |
| Combined hospitals | 86 | 239 | 2, 052 | 1, 964 | 88 | 96 | 1, 729 | 235 | 12 | 283 |
| Less than 200 beds | 47 | 109 | 625 | 547 | 78 | 88 | 459 | 88 | 16 | 146 |
| 200 to 299 | 50 | 79 | 420 | 373 | 47 | 89 | 180 | 193 | 52 | 94 |
| 300 to 499 | 206 | 1, 172 | 2, 632 | 2, 322 | 310 | 88 | 1, 481 | 841 | 36 | 606 |
| 500 over | 228 | 845 | 4, 760 | 4, 363 | 397 | 92 | 3, 377 | 986 | 23 | 1, 033 |
| Total | 617 | 1, 858 | 10, 489 | 9, 569 | 920 | 91 | 7, 226 | 2, 343 | 24 | 2, 162 |
| Nonaffiliated: |  |  |  |  |  |  |  |  |  |  |
| Combined hospitals | 4 | 12 | 89 | 83 | 6 | 93 | 41 | 42 | 51 | 23 |
| Less than 200 beds | 8 | 20 | 130 | 123 | 7 | 95 | 16 | 107 | 87 | --- |
| 200 to 299 | 35 | 74 | 329 | 282 | 44 | 87 | 20 | 262 | 93 | 78 |
| 300 to 499 | 60 | 310 | 772 | 658 | 114 | 85 | 145 | 513 | 78 | 177 |
| 500 over | 17 | 85 | 359 | 316 | 43 | 88 | 158 | 158 | 50 | 93 |
| Total | 124 | 346 | 1, 676 | 1, 462 | 214 | 87 | 380 | 1, 082 | 74 | 371 |
| Grand total | 741 | 2, 204 | 12, 165 | 11, 031 | 1, 134 | 91 | 7, 606 | 3, 425 | 31 | 2, 533 |

Source: "Directory of Approved Internships and Residencies, 1974–75," AMA, 1975.

TABLE 54.—*Annual salaries offered interns* [1]

| Annual salary offered | Programs in affiliated hospitals | Programs in nonaffiliated hospitals | Total programs |
|---|---|---|---|
| $5,001 to $5,500 | 7 | | 7 |
| $6,001 to $6,500 | 1 | | 1 |
| $6,501 to $7,000 | 56 | 4 | 60 |
| $7,001 to $7,500 | 39 | 2 | 41 |
| $7,501 to $8,000 | 65 | 25 | 90 |
| $8,001 to $8,500 | 124 | 59 | 183 |
| $8,501 to $9,000 | 272 | 46 | 318 |
| $9,001 to $9,500 | 331 | 47 | 378 |
| $9,501 to $10,000 | 502 | 103 | 605 |
| $10,001 to $10,500 | 312 | 51 | 363 |
| $10,501 to $11,000 | 218 | 71 | 289 |
| $11,001 to $11,500 | 72 | 9 | 81 |
| $11,501 to $12,000 | 39 | 14 | 53 |
| $12,001 to $12,500 | 95 | 27 | 122 |
| $12,501 to $13,000 | 34 | 20 | 54 |
| $13,001 to $13,500 | 7 | | 7 |
| $13,501 to $14,000 | 13 | 11 | 24 |
| $14,001 to $14,500 | 1 | 13 | 14 |
| $14,501 to $15,000 | 6 | | 6 |
| Over $15,000 | | | |
| Total programs reporting | 2, 194 | 502 | 2, 696 |
| Data not available | 187 | 30 | 217 |
| Total programs | 2, 381 | 532 | 2, 913 |
| Mean—Annual salary | $9, 827 | $10, 140 | $9, 886 |
| Median—Annual salary | 9, 501–10, 000 | 9, 501–10, 000 | 9, 501–10, 000 |
| Mode—Annual salary | 9, 501–10, 000 | 9, 501–10, 000 | 9, 501–10, 000 |

[1] Data collected prior to July 1, 1973. Data on internship salaries not collected in 1974.

Source: "Directory of Approved Internship and Residencies, 1973–74." AMA, 1973.

Tables 55 through 57 show number of residencies by specialty, number of residencies by medical school affiliation and bed capacity, and annual salaries offered residents.

## Table 55.—*Number of residencies, by specialty*

| Specialty | Number of residency positions | | | | | Number of residents on duty | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Number of approved programs | Total positions offered Sept. 1, 1973 | Total positions filled Sept. 1, 1973 | Positions vacant Sept. 1, 1973 | Percentage filled | Graduates United States, Canada Sept. 1, 1973 | Foreign graduates Sept. 1, 1973 | Percentage foreign graduates in filled positions | Total residency positions offered 1975–76 |
| Anesthesiology | 170 | 2, 211 | 2, 008 | 203 | 91 | 896 | 1, 112 | 55 | 2, 624 |
| Child psychiatry | 138 | 754 | 588 | 166 | 78 | 429 | 159 | 27 | 800 |
| Diagnostic radiology | 175 | 2, 147 | 2, 009 | 138 | 94 | 1, 766 | 243 | 12 | 2, 292 |
| Dermatology | 92 | 713 | 688 | 25 | 96 | 628 | 60 | 9 | 766 |
| Family practice | 206 | 2, 412 | 1, 765 | 647 | 73 | 1, 606 | 159 | 9 | 3, 832 |
| General practice | 51 | 343 | 260 | 83 | 76 | 53 | 207 | 80 | 527 |
| Surgery | 482 | 7, 616 | 7, 131 | 485 | 94 | 4, 600 | 2, 531 | 35 | 9, 121 |
| Internal medicine | 433 | 9, 816 | 9, 427 | 389 | 96 | 6, 601 | 2, 826 | 30 | 14, 709 |
| Neurological surgery | 100 | 641 | 609 | 32 | 95 | 490 | 119 | 20 | 643 |
| Neurology | 117 | 1, 088 | 981 | 107 | 90 | 716 | 265 | 27 | 1, 227 |
| Nuclear medicine | 26 | 46 | 41 | 5 | 89 | 22 | 19 | 46 | 83 |
| Obstetrics and gynecology | 347 | 3, 413 | 3, 183 | 230 | 93 | 2, 044 | 1, 139 | 36 | 3, 988 |
| Opthalmology | 177 | 1, 515 | 1, 500 | 15 | 99 | 1, 385 | 115 | 8 | 1, 577 |
| Orthopedic surgery | 207 | 2, 353 | 2, 268 | 85 | 96 | 2, 037 | 231 | 10 | 2, 568 |
| Otolaryngology | 113 | 1, 033 | 995 | 38 | 96 | 835 | 160 | 16 | 1, 071 |
| Pathology | 502 | 3, 509 | 2, 846 | 663 | 81 | 1, 327 | 1, 519 | 53 | 3, 753 |
| Forensic pathology | 30 | 54 | 31 | 23 | 57 | 24 | 7 | 23 | 68 |
| Neuropathology | 29 | 78 | 57 | 21 | 73 | 39 | 18 | 32 | 74 |
| Pediatrics | 274 | 4, 409 | 4, 231 | 178 | 96 | 2, 848 | 1, 383 | 33 | 5, 180 |
| Pediatric allergy | 46 | 110 | 99 | 11 | 90 | 75 | 24 | 24 | 131 |
| Pediatric cardiology | 56 | 152 | 120 | 32 | 79 | 73 | 47 | 39 | 159 |
| Physical medicine | 69 | 478 | 368 | 110 | 77 | 152 | 216 | 59 | 546 |
| Plastic surgery | 117 | 391 | 359 | 32 | 92 | 281 | 78 | 22 | 435 |
| Do | 1 | 3 | 3 | ---------- | 100 | 2 | 1 | 33 | 3 |
| Colon and rectal surgery | 20 | 33 | 30 | 3 | 91 | 18 | 12 | 40 | 39 |
| Psychiatry | 270 | 4, 992 | 4, 315 | 677 | 86 | 3, 008 | 1, 307 | 30 | 5, 413 |
| Radiology | 211 | 1, 415 | 1, 205 | 210 | 85 | 755 | 450 | 37 | 1, 617 |
| Therapeutic radiology | 97 | 480 | 348 | 132 | 73 | 206 | 142 | 41 | 526 |
| Thoracic surgery | 96 | 314 | 282 | 32 | 90 | 169 | 113 | 40 | 321 |
| Urology | 188 | 1, 169 | 1, 122 | 47 | 96 | 876 | 246 | 22 | 1, 264 |
| Total | 4, 840 | 53, 688 | 48, 869 | 4, 819 | 91 | 33, 961 | 14, 908 | 31 | 65, 357 |
| Other than hospitals: | | | | | | | | | |
| Aerospace medicine | 4 | 63 | 44 | 19 | 70 | 42 | 2 | 5 | 4 |
| General preventive medicine | 28 | 214 | 122 | 92 | 57 | 116 | 6 | 5 | 28 |
| Occupational medicine (academic) | 4 | 23 | 4 | 15 | 35 | 5 | 3 | 38 | 4 |
| Occupational medicine (in-plant) | 19 | 26 | 4 | 22 | 15 | 4 | 0 | ---------- | 19 |
| Public health | 23 | 123 | 35 | 88 | 28 | 31 | 4 | 11 | 23 |
| Totals—Other than hospitals | 78 | 449 | 209 | 236 | 47 | 198 | 15 | 7 | 78 |
| Grand total | 4, 918 | 54, 137 | 49, 078 | 5, 055 | 91 | 34, 159 | 14, 923 | 30 | 65, 435 |

Source: "Directory of Approved Internships and Residencies, 1974–75." AMA, 1975.

TABLE 56.—*Number of residencies, by medical school affiliates and bed capacity*

| Classification | Number of hospitals | Number of approved programs | Number of residencies | | | | Number of residents on duty | | | Total residency positions offered, 1975–76 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Total positions offered, Sept. 1, 1973 | Total positions filled, Sept. 1, 1973 | Positions vacant, Sept. 1, 1973 | Percentage filled | Graduates United States, Canada, Sept. 1, 1973 | Foreign graduates Sept. 1, 1973 | Percentage foreign graduates in filled positions | |
| Affiliated: | | | | | | | | | | |
| Combined hospitals | 161 | 1, 202 | 19, 645 | 18, 524 | 1, 121 | 94 | 14, 824 | 3, 700 | 20 | 23, 150 |
| Less than 200 beds | 217 | 250 | 2, 704 | 2, 402 | 302 | 89 | 1, 842 | 560 | 23 | 3, 099 |
| 200–299 | 109 | 187 | 1, 378 | 1, 229 | 149 | 89 | 878 | 351 | 29 | 1, 746 |
| 300 to 499 | 304 | 971 | 7, 693 | 6, 760 | 933 | 88 | 4, 216 | 2, 544 | 38 | 9, 800 |
| 500 or over | 309 | 1, 600 | 17, 283 | 15, 764 | 1, 519 | 91 | 10, 470 | 5, 294 | 34 | 21, 223 |
| Totals | 1, 100 | 4, 210 | 48, 703 | 44, 679 | 4, 024 | 92 | 32, 230 | 12, 449 | 28 | 59, 018 |
| Nonaffiliated: | | | | | | | | | | |
| Combined hospitals | 28 | 49 | 634 | 581 | 53 | 92 | 308 | 273 | 47 | 858 |
| Less than 200 beds | 184 | 135 | 931 | 723 | 208 | 336 | 325 | 398 | 55 | 1, 092 |
| 200 to 299 | 79 | 79 | 480 | 379 | 101 | 79 | 85 | 294 | 78 | 673 |
| 300 to 499 | 109 | 211 | 1, 382 | 1, 175 | 207 | 85 | 422 | 753 | 64 | 1, 914 |
| 500 or over | 77 | 156 | 1, 558 | 1, 332 | 226 | 85 | 591 | 741 | 56 | 1, 802 |
| Totals | 477 | 630 | 4, 985 | 4, 190 | 795 | 84 | 1, 731 | 2, 459 | 59 | 6, 339 |
| Grand totals | 1, 577 | 4, 840 | 53, 688 | 48, 869 | 4, 819 | 91 | 33, 961 | 14, 908 | 31 | 65, 357 |

Source: "Directory of Approved Internships and Residencies, 1974–75." AMA, 1975.

TABLE 57.—*Annual salaries offered residents*

| Annual salary offered | Programs in affiliated hospitals | Programs in nonaffiliated hospitals | Total programs |
|---|---|---|---|
| 0 to $3,500 | 1 | | 1 |
| $5,501 to $6,000 | 2 | 2 | 4 |
| $6,501 to $7,000 | 10 | | 10 |
| $7,001 to $7,500 | 7 | 1 | 8 |
| $7,501 to $8,000 | 14 | 1 | 15 |
| $8,001 to $8,500 | 30 | 8 | 38 |
| $8,501 to $9,000 | 84 | 13 | 97 |
| $9,001 to $9,500 | 197 | 15 | 212 |
| $9,501 to $10,000 | 374 | 39 | 413 |
| $10,001 to $10,500 | 424 | 68 | 492 |
| $10,501 to $11,000 | 436 | 70 | 506 |
| $11,001 to $11,500 | 356 | 26 | 382 |
| $11,501 to $12,000 | 323 | 38 | 361 |
| $12,001 to $12,500 | 123 | 12 | 135 |
| $12,501 to $13,000 | 70 | 25 | 95 |
| $13,001 to $13,500 | 112 | 69 | 181 |
| $13,501 to $14,000 | 66 | 6 | 72 |
| $14,001 to $14,500 | 33 | 19 | 52 |
| $14,501 to $15,000 | 132 | 41 | 173 |
| $15,001 to $15,500 | 48 | 10 | 58 |
| $15,501 to $16,000 | 16 | 7 | 23 |
| $16,001 to $16,500 | 19 | 1 | 20 |
| $16,501 to $17,000 | 16 | 1 | 17 |
| $17,001 to $17,500 | 6 | 2 | 8 |
| $17,501 to $18,000 | 1 | 2 | 3 |
| $18,001 to $18,500 | | 1 | 1 |
| $18,501 to $19,000 | 3 | 3 | 6 |
| $19,501 to $20,000 | 1 | | 1 |
| Over $20,000 | | 4 | 4 |
| Total programs reporting | 2, 904 | 484 | 3, 388 |
| Data not available | 1, 306 | 146 | 1, 452 |
| Total programs | 4, 210 | 630 | 4, 840 |
| Mean annual salary | $11, 249 | $12, 015 | $11, 359 |
| Median annual salary | $10, 501–$11, 000 | $11, 001–$11, 500 | $10, 501–$11, 000 |
| Mode annual salary | $10, 501–$11, 000 | $10, 501–$11, 000 | $10, 501–$11, 000 |

NOTE: Data collected prior to July 1, 1974.

Source: "Directory of Approved Internships and Residences 1974–75." AMA, 1975.

Tables 58 through 69 provide information on foreign medical graduates in U.S. graduate medical programs.

TABLE 58.—*Number of foreign graduates in U.S. graduate training programs, by origin of medical education, as of Dec. 31, 1974, and Dec. 31, 1973*

| Origin of medical training | Dec. 31, 1974 | | | Dec. 31, 1973 | | |
|---|---|---|---|---|---|---|
| | Interns | Residents | Total | Interns | Residents | Total |
| Africa | 72 | 446 | 518 | 79 | 507 | 586 |
| Americas | 439 | 2, 460 | 2, 899 | 478 | 2, 540 | 3, 018 |
| Asia | 2, 299 | 9, 886 | 12, 185 | 2, 580 | 9, 964 | 12, 544 |
| British Isles | 26 | 308 | 334 | 36 | 350 | 386 |
| Europe | 343 | 2, 007 | 2, 350 | 379 | 2, 180 | 2, 559 |
| Oceania | 9 | 127 | 136 | 9 | 119 | 128 |
| Total | 3, 188 | 15, 234 | 18, 422 | 3, 561 | 15, 660 | 19, 221 |

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 59.—*Foreign countries contributing greatest number of graduates to U.S. graduate programs as of Dec. 31, 1974*

| Country and rank order | Number of trainees | Percent of total number of foreign trainees in the United States | Rank as of Dec. 31, 1973 | Gain or loss in numbers |
|---|---|---|---|---|
| 1. India | 3, 900 | 21 | 1 | +169 |
| 2. Philippines | 2, 452 | 13 | 2 | −83 |
| 3. Korea | 1, 359 | 7 | 3 | —69 |
| 4. Formosa | 831 | 5 | 4 | —64 |
| 5. Iran | 822 | 4 | 5 | —69 |
| 6. Thailand | 620 | 3 | 6 | −109 |
| 7. Mexico | 598 | 3 | 10 | +110 |
| 8. Pakistan | 573 | 3 | 7 | —73 |
| 9. Italy | 501 | 3 | 8 | —21 |
| 10. Spain | 432 | 2 | 9 | —87 |
| 11. Argentina | 386 | 2 | 11 | —39 |
| 12. United Arab Republic | 319 | 2 | 12 | —86 |
| Total | 12, 793 | 69 | | −421 |

Source: Journal of the American Medical Association, Dec. 29, 1975. vol. 234, No. 13.

TABLE 60.—*Foreign medical graduates in training programs*

| Academic year | Interns | Residents | Other trainees | Total on duty |
|---|---|---|---|---|
| 1964–65 | 2, 821 | 8, 153 | 1, 925 | 12, 899 |
| 1965–66 | 2, 361 | 9, 113 | 2, 355 | 13, 829 |
| 1966–67 | 2, 793 | 9, 505 | 2, 566 | 14, 864 |
| 1967–68 | 2, 913 | 10, 627 | 3, 077 | 16, 617 |
| 1968–69 | 3, 270 | 11, 201 | 4, 046 | 18, 517 |
| 1969–70 | 2, 939 | 12, 060 | 3, 220 | 18, 219 |
| 1970–71 | 3, 339 | 12, 943 | 3, 331 | 19, 613 |
| 1971–72 | 3, 946 | 13, 520 | 4, 106 | 21, 572 |
| 1972–73 | 3, 924 | 14, 440 | 3, 595 | 21, 959 |
| 1973–74 | 3, 425 | 14, 908 | 3, 499 | 21, 832 |

Source: "Directory of Approved Internships and Residencies, 1974–75," AMA, 1975.

TABLE 61.—*Distribution of trainees in graduate programs, Sept. 1, 1973*

| | United States and Canadian graduates | | Foreign medical school graduates | | Total | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Interns | 7, 606 | 16 | 3, 425 | 16 | 11, 031 | 16 |
| Residents | 33, 961 | 72 | 14, 908 | 68 | 48, 869 | 71 |
| Other trainees | 5, 825 | 12 | 3, 499 | 16 | 9, 324 | 13 |
| Total | 47, 392 | 100 | 21, 832 | 100 | 69, 224 | 100 |

Source: "Directory of Approved Internships and Residencies, 1974–75." AMA, 1975.

TABLE 62.—*Status of internship and residency programs in the United States*

| | Internships | | | | | | | Residencies | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total offered | Total filled | Filled by non-foreign graduates | Filled by foreign graduates | Filled Federal services [1] | | Total vacant | Total offered | Total filled | Filled by non-foreign graduates | Filled by foreign graduates | Filled Federal services [1] | | Total vacant |
| | | | | | VA | Other | | | | | | VA | Other | |
| 1973–74 | 12, 165 | 11, 031 | 7, 606 | 3, 425 | 83 | 475 | 1, 134 | 54, 137 | 49, 078 | 34, 159 | 14, 923 | 1, 022 | 1, 946 | 4, 819 |
| 1972–73 | 13, 650 | 11, 163 | 7, 239 | 3, 924 | 72 | 503 | 2, 487 | 51, 658 | 45, 081 | 30, 610 | 14, 471 | 1, 176 | 1, 881 | 6, 577 |
| 1971–72 | 15, 422 | 12, 066 | 8, 120 | 3, 946 | 43 | 527 | 3, 356 | 50, 193 | 42, 512 | 28, 970 | 13, 543 | 1, 062 | 1, 847 | 7, 681 |
| 1970–71 | 15, 354 | 11, 552 | 8, 213 | 3, 339 | 96 | 587 | 3, 802 | 46, 584 | 39, 463 | 26, 495 | 12, 968 | 1, 162 | 1, 722 | 7, 121 |
| 1969–70 | 15, 003 | 10, 808 | 7, 869 | 2, 939 | 47 | 501 | 4, 195 | 45, 351 | 37, 139 | 25, 013 | 12, 126 | 1, 391 | 1, 570 | 8, 212 |
| 1968–69 | 14, 112 | 10, 464 | 7, 194 | 3, 270 | 47 | 540 | 3, 648 | 42, 633 | 35, 047 | 23, 816 | 11, 231 | 1, 115 | 1, 652 | 7, 597 |
| 1967–68 | 13, 761 | 10, 419 | 7, 506 | 2, 913 | 74 | 575 | 3, 342 | 41, 695 | 33, 743 | 23, 116 | 10, 627 | 1, 329 | 1, 531 | 7, 952 |
| 1966–67 | 13, 569 | 10, 366 | 7, 573 | 2, 793 | 73 | 663 | 3, 203 | 39, 384 | 32, 050 | 22, 548 | 9, 502 | 1, 590 | 1, 548 | 7, 334 |
| 1965–66 | 12, 954 | 9, 670 | 7, 309 | [2] 2, 361 | 93 | 613 | 3, 284 | 38, 979 | 31, 898 | 22, 765 | [2] 9, 133 | 1, 753 | 1, 352 | 7, 074 |
| 1964–65 | 12, 728 | 10, 097 | 7, 276 | 2, 821 | 46 | 563 | 2, 631 | 38, 750 | 31, 005 | 22, 852 | 8, 153 | 2, 127 | 1, 353 | 7, 749 |
| 1963–64 | 12, 229 | 9, 636 | 7, 070 | 2, 566 | 45 | 569 | 2, 593 | 37, 357 | 29, 485 | 22, 433 | 7, 052 | 2, 104 | 1, 338 | 7, 728 |
| 1962–63 | 12, 024 | 8, 805 | 7, 136 | 1, 669 | 41 | 533 | 3, 219 | 36, 502 | 29, 239 | 22, 177 | 7, 062 | 2, 464 | 1, 223 | 7, 263 |
| 1961–62 [4] | 12, 074 | 8, 173 | 6, 900 | 1, 273 | 42 | 581 | 3, 901 | 35, 403 | 29, 637 | 21, 914 | [3] 7, 723 | 2, 602 | 1, 249 | 5, 766 |
| 1960–61 [4] | 12, 547 | 9, 115 | 7, 362 | [3] 1, 753 | 71 | 576 | 3, 432 | 32, 786 | 28, 447 | 20, 265 | 8, 182 | 2, 830 | 1, 177 | 4, 339 |
| 1959–60 | 12, 580 | 10, 253 | 7, 708 | 2, 545 | 55 | 584 | 2, 327 | 31, 733 | 27, 590 | 20, 619 | 6, 912 | 2, 650 | 1, 455 | 4, 143 |
| 1958–59 | 12, 469 | 10, 352 | 8, 037 | 2, 315 | 25 | 567 | 2, 117 | 31, 818 | 26, 758 | 20, 716 | 6, 042 | 2, 453 | 1, 267 | 5, 060 |
| 1957–58 | 12, 325 | 10, 198 | 8, 119 | 2, 079 | 48 | 566 | 2, 127 | 30, 595 | 24, 976 | 19, 433 | 5, 543 | 2, 403 | 1, 049 | 5, 619 |
| 1956–57 | 11, 895 | 9, 893 | 7, 905 | 1, 988 | 58 | 532 | 2, 002 | 28, 528 | 23, 012 | 18, 259 | 4, 753 | 2, 304 | 1, 276 | 5, 516 |
| 1955–56 | 11, 616 | 9, 603 | 7, 744 | 1, 859 | 55 | 495 | 2, 013 | 26, 516 | 21, 425 | 17, 251 | 4, 174 | 2, 353 | 624 | 5, 091 |
| 1954–55 | 11, 048 | 9, 066 | 7, 305 | 1, 761 | 88 | 470 | 1, 982 | 25, 486 | 20, 494 | 17, 219 | 3, 275 | 2, 252 | 657 | 4, 992 |
| 1953–54 | 10, 542 | 8, 275 | 6, 488 | 1, 787 | 88 | 433 | 2, 267 | 23, 630 | 18, 619 | 14, 817 | 3, 802 | 2, 072 | 639 | 5, 011 |
| 1952–53 | 10, 548 | 7, 645 | 6, 292 | 1, 353 | 67 | 393 | 2, 903 | 22, 292 | 16, 867 | 13, 832 | 3, 035 | 2, 021 | 768 | 5, 425 |
| 1951–52 | 10, 044 | 7, 866 | 6, 750 | 1, 116 | 71 | 472 | 2, 178 | 20, 645 | 15, 851 | 13, 618 | 2, 233 | 2, 120 | 761 | 4, 794 |
| 1950–51 | 9, 370 | 7, 030 | 6, 308 | 722 | ---- | 435 | 2, 340 | 19, 364 | 14, 495 | 13, 145 | 1, 350 | ---- | ---- | 4, 869 |
| 1949–50 | 9, 124 | 7, 313 | ---- | (5) | ---- | ---- | 1, 811 | 18, 669 | 17, 490 | ---- | (5) | ---- | ---- | 1, 179 |
| 1948–49 | 9, 027 | 7, 248 | ---- | ---- | ---- | ---- | 1, 779 | 17, 293 | ---- | ---- | ---- | ---- | ---- | ---- |
| 1947–48 | 8, 683 | 6, 902 | ---- | ---- | ---- | ---- | 1, 781 | 15, 172 | ---- | ---- | ---- | ---- | ---- | ---- |
| 1946–47 | 8, 584 | ---- | ---- | ---- | ---- | ---- | ---- | 12, 003 | ---- | ---- | ---- | ---- | ---- | ---- |
| 1945–46 | 8, 429 | ---- | ---- | ---- | ---- | ---- | ---- | 8, 930 | ---- | ---- | ---- | ---- | ---- | ---- |
| World War II, 1941–42 | 8, 182 | ---- | ---- | ---- | ---- | ---- | ---- | 5, 256 | ---- | ---- | ---- | ---- | ---- | ---- |

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[1] Figures for filled Federal services also included in preceding columns.
[2] 1965—Amendments to Immigration and Nationality Act.
[3] 1961—E.C.F.M.G. deadline imposed.
[4] 1961—Fulbright-Hays Act, exchange-visitor program.
[5] 1949—Smith-Mundt Act, exchange-visitor programs.

Source: "Directory of Approved Internships and Residencies, 1974–75." AMA, 1975.

TABLE 63.—*Number of foreign graduate trainees in the United States, by origin of medical education as of Dec. 31, 1973, and 1972*

| Origin of medical training | Interns | | Residents | | Total | |
|---|---|---|---|---|---|---|
| | 1973 | 1972 | 1973 | 1972 | 1973 | 1972 |
| Total | 3, 561 | 3, 247 | 15, 660 | 14, 465 | 19, 221 | 17, 712 |
| Africa | 79 | 66 | 507 | 484 | 586 | 550 |
| Algeria | 0 | 0 | 0 | 1 | 0 | 1 |
| Congo | 0 | 0 | 1 | 1 | 1 | 1 |
| Ethiopia | 1 | 0 | 0 | 1 | 1 | 1 |
| Nigeria | 7 | 8 | 50 | 44 | 57 | 52 |
| Rhodesia | 0 | 0 | 0 | 0 | 0 | 0 |
| Sudan | 0 | 0 | 0 | 2 | 0 | 2 |
| Uganda | 7 | 8 | 29 | 19 | 36 | 27 |
| Union of South Africa | 9 | 8 | 77 | 72 | 86 | 80 |
| United Arab Republic | 55 | 42 | 350 | 344 | 405 | 386 |
| Americas | 478 | 504 | 2, 540 | 2, 265 | 3, 018 | 2, 769 |
| Argentina | 70 | 73 | 355 | 320 | 425 | 393 |
| Bolivia | 11 | 19 | 73 | 55 | 84 | 74 |
| Brazil | 57 | 34 | 180 | 150 | 237 | 184 |
| Chile | 21 | 10 | 119 | 84 | 140 | 94 |
| Colombia | 28 | 46 | 301 | 271 | 329 | 317 |
| Costa Rica | 5 | 3 | 25 | 19 | 30 | 22 |
| Cuba | 30 | 38 | 146 | 144 | 176 | 182 |
| Dominican Republic | 35 | 27 | 108 | 106 | 143 | 133 |
| Ecuador | 10 | 13 | 65 | 51 | 75 | 64 |
| El Salvador | 13 | 20 | 61 | 41 | 74 | 61 |
| Guatemala | 18 | 9 | 55 | 50 | 73 | 59 |
| Haiti | 17 | 24 | 92 | 86 | 109 | 110 |
| Honduras | 2 | 7 | 33 | 24 | 35 | 31 |
| Jamaica | 6 | 12 | 46 | 45 | 52 | 57 |
| Mexico | 67 | 55 | 421 | 403 | 488 | 458 |
| Nicaragua | 4 | 7 | 39 | 31 | 43 | 38 |
| Panama | 4 | 1 | 9 | 10 | 13 | 11 |
| Paraguay | 14 | 9 | 46 | 46 | 60 | 55 |
| Peru | 42 | 58 | 235 | 223 | 277 | 281 |
| Uruguay | 5 | 7 | 26 | 23 | 31 | 30 |
| Venezuela | 19 | 32 | 105 | 83 | 124 | 115 |
| Asia | 2, 580 | 2, 229 | 9, 964 | 9, 189 | 12, 544 | 11, 418 |
| Afghanistan | 1 | 1 | 15 | 14 | 17 | 15 |
| Bangladesh | 16 | 7 | 19 | 6 | 35 | 13 |
| Burma | 24 | 10 | 69 | 74 | 93 | 84 |
| Cambodia | 2 | 1 | 1 | 0 | 3 | 1 |
| Ceylon | 29 | 32 | 200 | 157 | 229 | 189 |
| China (Mainland) | 10 | 16 | 32 | 56 | 42 | 72 |
| Formosa | 187 | 266 | 708 | 623 | 895 | 889 |
| Hong Kong | 5 | 17 | 54 | 45 | 59 | 62 |
| India | 684 | 614 | 3, 047 | 2, 615 | 3, 731 | 3, 229 |
| Indonesia | 12 | 19 | 88 | 78 | 100 | 97 |
| Iran | 213 | 128 | 678 | 641 | 891 | 769 |
| Iraq | 11 | 13 | 50 | 56 | 61 | 69 |
| Israel | 4 | 6 | 111 | 83 | 115 | 89 |
| Japan | 47 | 58 | 261 | 254 | 308 | 312 |
| Korea | 428 | 279 | 1, 000 | 892 | 1, 428 | 1, 171 |
| Lebanon | 10 | 19 | 184 | 172 | 194 | 191 |
| Malaysia | 1 | 1 | 5 | 4 | 6 | 5 |
| Manchuria | 0 | 2 | 2 | 2 | 2 | 4 |
| Pakistan | 91 | 91 | 555 | 524 | 646 | 615 |
| Philippines | 575 | 489 | 1, 960 | 1, 951 | 2, 535 | 2, 440 |
| Singapore | 3 | 7 | 25 | 19 | 28 | 26 |
| Syria | 90 | 39 | 174 | 131 | 264 | 170 |
| Thailand | 105 | 97 | 624 | 692 | 729 | 789 |
| Turkey | 30 | 16 | 90 | 91 | 120 | 107 |
| Vietnam (North) | 0 | 1 | 0 | 0 | 0 | 1 |
| Vietnam (South) | 1 | 0 | 12 | 9 | 13 | 9 |

Table 63.—*Number of foreign graduate trainees in the United States, by origin of medical education as of Dec. 31, 1973, and 1972*—Continued

| Origin of medical training | Interns |  | Residents |  | Total |  |
|---|---|---|---|---|---|---|
|  | 1973 | 1972 | 1973 | 1972 | 1973 | 1972 |
| British Isles | 36 | 62 | 350 | 332 | 386 | 394 |
| England (United Kingdom) | 1 | 1 | 35 | 51 | 36 | 52 |
| Ireland (Republic) | 21 | 41 | 178 | 173 | 199 | 214 |
| Ireland (United Kingdom) | 0 | 0 | 3 | 5 | 3 | 5 |
| Scotland (United Kingdom) | 7 | 9 | 56 | 56 | 63 | 65 |
| Wales (United Kingdom) | 7 | 11 | 78 | 47 | 85 | 58 |
| Europe | 379 | 377 | 2,180 | 2,083 | 2,559 | 2,460 |
| Austria | 8 | 7 | 47 | 48 | 55 | 55 |
| Belgium | 10 | 11 | 125 | 130 | 135 | 141 |
| Bulgaria | 3 | 5 | 14 | 13 | 17 | 18 |
| Czechoslovakia | 4 | 19 | 73 | 86 | 77 | 105 |
| Denmark | 1 | 6 | 12 | 11 | 13 | 17 |
| Estonia | 0 | 0 | 0 | 0 | 0 | 0 |
| Finland | 1 | 0 | 6 | 8 | 7 | 8 |
| France | 19 | 7 | 68 | 51 | 87 | 58 |
| Germany (E) | 0 | 0 | 1 | 1 | 1 | 1 |
| Germany (W) | 53 | 41 | 261 | 280 | 314 | 321 |
| Greece | 35 | 29 | 161 | 143 | 196 | 172 |
| Hungary | 5 | 7 | 38 | 34 | 43 | 41 |
| Iceland | 2 | 3 | 17 | 18 | 19 | 21 |
| Italy | 82 | 85 | 440 | 369 | 522 | 454 |
| Latvia | 0 | 0 | 0 | 0 | 0 | 0 |
| Lithuania | 0 | 1 | 1 | 0 | 1 | 1 |
| Malta | 0 | 0 | 0 | 2 | 0 | 2 |
| Netherlands | 4 | 6 | 24 | 32 | 28 | 38 |
| Norway | 0 | 1 | 6 | 7 | 6 | 8 |
| Poland | 20 | 27 | 96 | 96 | 116 | 123 |
| Portugal | 4 | 1 | 15 | 17 | 19 | 18 |
| Romania | 5 | 13 | 65 | 65 | 70 | 78 |
| Spain | 68 | 66 | 451 | 426 | 519 | 492 |
| Sweden | 2 | 2 | 13 | 3 | 15 | 5 |
| Switzerland | 25 | 27 | 139 | 148 | 164 | 175 |
| U.S.S.R | 2 | 1 | 10 | 7 | 12 | 8 |
| Yugoslavia | 26 | 12 | 97 | 88 | 123 | 100 |
| Oceania | 9 | 9 | 119 | 112 | 128 | 121 |
| Australia | 9 | 7 | 99 | 92 | 108 | 99 |
| New Zealand | 0 | 2 | 20 | 20 | 20 | 22 |

Source: "Directory of Approved Internships and Residencies, 1974–75," AMA, 1975.

TABLE 64.—*12 foreign medical schools contributing the largest number of graduates to U.S. graduate medical education programs, Dec. 31, 1974*

| School | Interns | Residents | Total | Rank as of December 1973 |
|---|---|---|---|---|
| 1. University of Santo Tomas, Faculty of Medicine and Surgery, Manila, Philippines | 201 | 880 | 1, 081 | 1 |
| 2. University of Tehran, Faculty of Medicine, Tehran, Iran | 72 | 468 | 540 | 2 |
| 3. Far Eastern University, Institute of Medicine, Manila, Philippines | 81 | 362 | 443 | 3 |
| 4. University of Bombay, Grant Medical College-Seth Gorhandas Sunderdas Medical College, Bombay, India | 76 | 321 | 397 | 4 |
| 5. Universita di Bologna, Facolta di Medicina e Chirurgia, Bologna, Italy | 39 | 294 | 333 | 5 |
| 6. Seoul National University, College of Medicine, Seoul, Korea | 73 | 248 | 321 | 7 |
| 7. University of East, College of Medicine, Quezon City, Philippines | 80 | 210 | 290 | 9 |
| 8. Damascus University Medical College, Damascus, Syria | 64 | 225 | 289 | 12 |
| 9. University of Medical Sciences, Faculty of Medicine at Siriaj Hospital, Thonburi, Thailand | 40 | 245 | 285 | 6 |
| 10. Baroda University Medical College, Baroda Gujarat, India | 39 | 230 | 269 | 8 |
| 11. Universidad Nacional Autonama de Mexico Faculted de Medicina, Ciudad Universitaria, Mexico City | 26 | 214 | 240 | 10 |
| 12. University of the Philippines, College of Medicine, Manila, Philippines | 40 | 188 | 237 | 11 |
| Total | 840 | 3, 885 | 4, 725 | |

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 65.—*Women in internship positions, as of Sept. 1, 1974*

| State | Types of medical school affiliation | | | | | | | | | | Total U.S. and foreign graduates |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | United States and Canadian graduates | | | | | Foreign graduates | | | | | |
| | Major | Limited | Graduate | None | Total | Major | Limited | Graduate | None | Total | |
| Alabama | 4 | 3 | | 7 | 14 | | | | 1 | 1 | 15 |
| Alaska | | | | | | | | | | | |
| Arizona | 7 | 7 | | | 14 | 1 | | | | 1 | 15 |
| Arkansas | 3 | | | | 3 | 1 | | | | 1 | 4 |
| California | 185 | 25 | 22 | 3 | 235 | 12 | 4 | 2 | | 18 | 253 |
| Canal Zone | | | 2 | | 2 | | | | | | 2 |
| Colorado | | 5 | 5 | | 10 | | | | | | 10 |
| Connecticut | 14 | 3 | 1 | | 18 | 9 | 2 | 4 | | 15 | 33 |
| Delaware | | | | | | | | | | | |
| District of Columbia | 17 | 9 | | | 26 | 1 | 1 | 5 | | 7 | 33 |
| Florida | 16 | 1 | | | 17 | 1 | 2 | | 1 | 4 | 21 |
| Georgia | 15 | | 1 | 1 | 17 | | | 1 | 4 | 5 | 22 |
| Guam | | | | | | | | | | | |
| Hawaii | | 7 | | | 7 | | 3 | | | 3 | 10 |
| Idaho | | | | | | | | | | | |
| Illinois | 51 | 3 | | | 54 | 55 | 40 | 3 | 14 | 112 | 166 |
| Indiana | 5 | 3 | | | 8 | | | | | | 8 |
| Iowa | 6 | 2 | | | 8 | | 1 | | 1 | 2 | 10 |
| Kansas | 1 | 1 | | | 2 | | | | | | 2 |
| Kentucky | 5 | 4 | | 2 | 11 | 4 | | | | 4 | 15 |
| Louisiana | 14 | | | | 14 | 6 | | | | 6 | 20 |
| Maine | 3 | | | | 3 | | | | | | 3 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Maryland | 24 | 2 | | 1 | 27 | 2 | | 10 | 15 | 27 | 54 |
| Massachusetts | 42 | 3 | | | 45 | 9 | 6 | | 2 | 17 | 62 |
| Michigan | 21 | 2 | | 5 | 28 | 22 | 11 | | 18 | 51 | 79 |
| Minnesota | 22 | 2 | | | 24 | | 1 | | | 1 | 25 |
| Mississippi | 1 | | | | 1 | | | | | | 1 |
| Missouri | 33 | 1 | | | 34 | 34 | 5 | 4 | 5 | 48 | 82 |
| Nebraska | 3 | | | | 3 | 1 | | | | 1 | 4 |
| New Hampshire | 2 | | | | 2 | | | | | | 2 |
| New Jersey | 8 | | | 1 | 9 | 29 | 18 | 3 | 11 | 61 | 70 |
| New Mexico | 8 | | | | 8 | | | | | | 8 |
| New York | 109 | 1 | 3 | 23 | 136 | 111 | 24 | 7 | 26 | 168 | 304 |
| North Carolina | 24 | | | | 24 | | | | | | 24 |
| Ohio | 32 | | | 1 | 33 | 5 | 6 | | 13 | 24 | 57 |
| Oklahoma | 3 | 2 | | | 5 | 1 | | | | | 6 |
| Oregon | 4 | 4 | | | 8 | | | | | | 8 |
| Pennsylvania | 63 | 5 | 1 | | 69 | 24 | 15 | 7 | 11 | 57 | 126 |
| Puerto Rico | 8 | | | | 8 | 4 | 2 | | | 6 | 14 |
| Rhode Island | 5 | | | | 5 | | 2 | | | 2 | 7 |
| South Carolina | 1 | | | | 1 | | 1 | | | 1 | 2 |
| Tennessee | 14 | 1 | 1 | | 16 | 1 | 2 | | 1 | 4 | 20 |
| Texas | 73 | 7 | | 1 | 81 | 3 | | | | 3 | 84 |
| Utah | 1 | | 2 | | 3 | | | | | | 3 |
| Vermont | 2 | | | | 2 | | | | | | 2 |
| Virginia | 17 | 1 | | | 18 | 2 | | | | 2 | 20 |
| Washington | 4 | 8 | | | 12 | | | | | | 12 |
| West Virginia | | | | | | 1 | | | | 1 | 1 |
| Wisconsin | 23 | 3 | | | 26 | | 5 | | | 5 | 31 |
| Total | 893 | 115 | 38 | 45 | 1, 091 | 339 | 151 | 46 | 123 | 659 | 1, 750 |

Source: Journal of the American Medical Association, Dec. 29, 1975, v. 234, No. 13.

TABLE 66.—*Women physicians serving in residences, by specialty and hospital affiliation, as of Sept. 1, 1974*

| Specialty | Types of medical school affiliation | | | | | | | | | | Total on duty United States and foreign |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | United States and Canadian graduates | | | | | Foreign graduates | | | | | |
| | Major | Limited | Graduate | None | Total | Major | Limited | Graduate | None | Total | |
| Anesthesiology | 106 | | | 1 | 107 | 231 | 20 | 6 | 28 | 285 | 392 |
| Child psychiatry | 50 | 7 | | 4 | 61 | 35 | 20 | 3 | 12 | 70 | 131 |
| Diagnostic radiology | 32 | 1 | | 8 | 41 | 15 | 3 | | | 16 | 57 |
| Dermatology | 62 | | | 1 | 63 | 14 | 1 | | | 15 | 78 |
| Family practice | 75 | 31 | 3 | 24 | 133 | 21 | 11 | 6 | 10 | 48 | 181 |
| General practice | 1 | | | 1 | 2 | 4 | 23 | 3 | 36 | 66 | 68 |
| General surgery | 162 | 12 | 5 | 8 | 187 | 83 | 9 | | 6 | 98 | 288 |
| Internal medicine | 459 | 44 | 4 | 27 | 534 | 171 | 65 | 23 | 70 | 329 | 863 |
| Neurological surgery | 15 | | | | 15 | 7 | | | | 7 | 22 |
| Neurology | 56 | 1 | | 3 | 60 | 32 | 2 | | | 34 | 94 |
| Nuclear medicine | 3 | 1 | | 1 | 5 | 3 | | | | 3 | 8 |
| Obstetrics-gynecology | 137 | 14 | 2 | 14 | 167 | 102 | 30 | 9 | 40 | 181 | 348 |
| Opthalmology | 43 | 2 | 3 | 6 | 54 | 14 | 3 | | 2 | 19 | 73 |
| Orthopedic surgery | 12 | | | 1 | 13 | 1 | | | | 1 | 14 |
| Otolaryngology | 10 | | | | 10 | 1 | | | | 1 | 11 |
| Pathology | 145 | 30 | 3 | 6 | 184 | 254 | 104 | 15 | 78 | 451 | 635 |
| Forensic pathology | | | | 1 | 1 | | | | 3 | 3 | 4 |
| Pediatrics | 517 | 59 | 5 | 14 | 595 | 403 | 64 | 24 | 87 | 578 | 1, 173 |
| Pediatric allergy | 3 | 3 | | | 6 | 1 | | | | 1 | 7 |
| Pediatric cardiology | 3 | | | 1 | 4 | 3 | | | 2 | 5 | 9 |
| Physical medicine and rehabilitation | 25 | | 1 | 1 | 27 | 84 | 17 | | 20 | 121 | 143 |
| Plastic surgery | 6 | | | 2 | 8 | 2 | | | 1 | 3 | 11 |
| General preventive medicine | 2 | | | 1 | 3 | | | | | | 3 |
| Colon and rectal surgery | | | | 1 | 1 | | | | | | 1 |
| Psychiatry | 356 | 34 | 4 | 27 | 421 | 218 | 38 | 14 | 187 | 457 | 878 |
| Radiology | 129 | 7 | 4 | 12 | 152 | 63 | 14 | 3 | 21 | 101 | 253 |
| Therapeutic radiology | 9 | | | 1 | 10 | 11 | | | | 11 | 21 |
| Thoracic surgery | 1 | | | | 1 | 3 | | | | 3 | 4 |
| Urology | 1 | | | | 1 | | | | | | 1 |
| Other specialties | 32 | 1 | | 3 | 36 | 19 | 5 | | 1 | 24 | 61 |
| Total | 2, 452 | 247 | 34 | 169 | 2, 902 | 1, 793 | 429 | 106 | 604 | 2, 932 | 5, 834 |

Source: Journal of the American Medical Association, Dec. 29, 1975, v. 234, No. 13.

TABLE 67.—*Male and female graduates as of June 30, 1974*

| | Men | Percent of total class | Women | Percent of total class | Total class |
|---|---|---|---|---|---|
| Graduates of medical schools in: | | | | | |
| United States | 10, 101 | 88. 9 | 1, 264 | 11. 1 | 11, 365 |
| Canada | 1, 253 | 80. 2 | 309 | 19. 8 | 1, 562 |
| Total graduates | 11, 354 | 87. 8 | 1, 573 | 12. 2 | 12, 927 |

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 68.—*Black U.S. citizens serving in internship and residency programs as of Sept. 1, 1974*

| State | Number of hospitals appointing black house officers | Black citizens in internships | | | Black citizens in residencies | | | Total on duty |
|---|---|---|---|---|---|---|---|---|
| | | United States and Canada graduates | Foreign graduates | Total | United States and Canada graduates | Foreign graduates | Total | |
| Alabama | 6 | 4 | 2 | 6 | 4 | 6 | 10 | 16 |
| Arizona | 3 | 1 | | 1 | 1 | 3 | 4 | 5 |
| Arkansas | 1 | 1 | | 1 | 1 | | 1 | 2 |
| California | 45 | 38 | | 38 | 119 | 3 | 122 | 160 |
| Canal Zone | 1 | 1 | | 1 | | | | 1 |
| Colorado | 5 | 4 | 1 | 5 | 9 | | 9 | 14 |
| Connecticut | 9 | 4 | 3 | 7 | 16 | 5 | 21 | 28 |
| Delaware | 1 | 3 | | 3 | 1 | | 1 | 4 |
| District of Columbia | 11 | 69 | | 69 | 161 | 3 | 164 | 233 |
| Florida | 6 | 7 | | 7 | 11 | 14 | 25 | 32 |
| Georgia | 8 | 12 | 2 | 14 | 18 | 5 | 23 | 37 |
| Hawaii | 4 | 2 | | 2 | 4 | | 4 | 6 |
| Illinois | 12 | 28 | 1 | 29 | 43 | 4 | 47 | 76 |
| Indiana | 3 | 1 | | 1 | 2 | 2 | 4 | 5 |
| Iowa | 3 | | | | 2 | 1 | 3 | 3 |
| Kansas | 2 | 1 | | 1 | 3 | 2 | 5 | 6 |
| Kentucky | 1 | 1 | | 1 | | | | 1 |
| Louisiana | 3 | 8 | | 8 | 1 | 44 | 45 | 53 |
| Maryland | 16 | 19 | 8 | 27 | 27 | 18 | 45 | 72 |
| Massachusetts | 18 | 10 | | 10 | 31 | 9 | 40 | 50 |
| Michigan | 20 | 26 | | 26 | 43 | 1 | 44 | 70 |
| Minnesota | 3 | | | | 9 | 8 | 17 | 17 |
| Mississippi | 5 | 3 | | 3 | 3 | | 3 | 6 |
| Missouri | 16 | 8 | 1 | 9 | 21 | 8 | 29 | 38 |
| Nebraska | 3 | | | | 3 | 1 | 4 | 4 |
| New Hampshire | 1 | 1 | | 1 | | | | 1 |
| New Jersey | 7 | 3 | 28 | 31 | 11 | 3 | 14 | 45 |
| New York | 52 | 49 | 5 | 54 | 144 | 27 | 171 | 225 |
| North Carolina | 4 | 1 | | 1 | 7 | | 7 | 8 |
| North Dakota | 1 | 1 | | 1 | | | | 1 |
| Ohio | 17 | 17 | | 17 | 29 | 4 | 33 | 50 |
| Oklahoma | 2 | | 4 | 4 | 1 | 2 | 3 | 7 |
| Oregon | 2 | 1 | | 1 | | 2 | 2 | 3 |
| Pennsylvania | 25 | 16 | | 16 | 35 | 7 | 42 | 58 |
| South Carolina | 2 | 1 | | 1 | 1 | 28 | 29 | 30 |
| Tennessee | 4 | 2 | 2 | 4 | 2 | 55 | 57 | 61 |
| Texas | 17 | 6 | | 6 | 42 | 23 | 65 | 71 |
| Virginia | 8 | 5 | 2 | 7 | 9 | 2 | 11 | 18 |
| Washington | 2 | 6 | | 6 | 3 | | 3 | 9 |
| West Virginia | 1 | | | | | 2 | 2 | 2 |
| Wisconsin | 3 | 2 | | 2 | 4 | | 4 | 6 |
| Total | 353 | 362 | 59 | 421 | 821 | 292 | 1, 113 | 1, 534 |

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 69.—*Black U.S. citizens serving in residencies, by specialty and hospital affiliation, as of Sept. 1, 1974*

| Specialty | Types of medical school affiliations | | | | | | | | | | Total on duty, United States, Canadian, and foreign graduates |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | United States and Canadian graduates | | | | | Foreign graduates | | | | | |
| | Major | Limited | Graduate | None | Total | Major | Limited | Graduate | None | Total | |
| Anesthesiology | 10 | | | | 10 | 14 | 1 | | | 15 | 25 |
| Child psychiatry | 3 | 5 | | | 8 | 1 | 1 | | | 2 | 10 |
| Diagnostic radiology | 1 | | | | 1 | | | | | | 1 |
| Dermatology | 13 | | | | 13 | | | | | | 13 |
| Family practice | 29 | 9 | 1 | 6 | 45 | 5 | | | | 5 | 50 |
| General practice | | | | 1 | 1 | | | | 1 | 1 | 2 |
| General surgery | 87 | 17 | 11 | 5 | 120 | 22 | 2 | | 3 | 27 | 147 |
| Internal medicine | 140 | 22 | 13 | 10 | 185 | 60 | 4 | | 6 | 70 | 255 |
| Neurological surgery | 8 | | | | 8 | 1 | | | | 1 | 9 |
| Neurology | 9 | | | | 9 | 13 | | | | 13 | 22 |
| Nuclear medicine | | | | | | 1 | | | | 1 | 1 |
| Obstetrics-gynecology | 91 | 15 | 14 | 7 | 127 | 20 | 3 | | 4 | 27 | 154 |
| Ophthalmology | 19 | 7 | | 2 | 28 | 1 | | | 3 | 4 | 32 |
| Orthopedic surgery | 32 | 1 | 4 | 4 | 41 | 1 | | 2 | | 3 | 44 |
| Otolaryngology | 12 | 1 | | | 13 | 4 | | | | 4 | 17 |
| Pathology | 13 | 2 | | 1 | 16 | 12 | 3 | | 2 | 17 | 33 |
| Forensic pathology | | | | | | | | | 1 | 1 | 1 |
| Pediatrics | 50 | 6 | 6 | | 62 | 25 | | | 2 | 27 | 89 |
| Pediatric allergy | 1 | | | | 1 | 1 | | | | 1 | 2 |
| Pediatric cardiology | | | | | | 1 | | | | 1 | 1 |
| Physical medicine and rehabilitation | 1 | | | 2 | 3 | 1 | | | | 1 | 4 |
| Plastic surgery | 2 | | | | 2 | 1 | | | | 1 | 3 |
| Psychiatry | 47 | 3 | | 6 | 56 | 23 | 1 | 1 | 7 | 32 | 88 |
| Radiology | 18 | 3 | 3 | 1 | 25 | 8 | | | | 8 | 33 |
| Therapeutic radiology | 2 | | | | 2 | 8 | | | | 8 | 10 |
| Thoracic surgery | 2 | 1 | | 1 | 4 | 11 | | | | 11 | 15 |
| Urology | 18 | | | 1 | 19 | 2 | | | | 2 | 21 |
| Other specialties | 16 | 2 | 3 | 1 | 22 | 8 | 1 | | | 9 | 31 |
| Total | 624 | 94 | 55 | 48 | 821 | 244 | 16 | 3 | 29 | 292 | 1, 113 |

Source: Journal of the American Medical Association, Dec. 29, 1975, vol. 234, No. 13.

TABLE 70.—*Twelve U.S. medical schools contributing the largest number of graduates to U.S. graduate medical education programs, Dec. 31, 1974*

| School | Interns | Residents | Total | Rank as of December 1973 |
|---|---|---|---|---|
| 1. University of Illinois College of Medicine, Chicago | 137 | 780 | 917 | 1 |
| 2. Ohio State University College of Medicine, Columbus, Ohio | 140 | 715 | 855 | 2 |
| 3. Indiana University School of Medicine, Indianapolis | 166 | 685 | 851 | 4 |
| 4. State University of New York Downstate Medical Center, Brooklyn, N.Y | 144 | 689 | 833 | 5 |
| 5. University of Michigan Medical School, Ann Arbor, Mich | 160 | 658 | 818 | 3 |
| 6. Jefferson Medical College of Thomas Jefferson University, Philadelphia | 128 | 671 | 799 | 6 |
| 7. University of Minnesota Medical School, Minneapolis | 189 | 605 | 794 | 7 |
| 8. Harvard Medical School, Boston | 131 | 534 | 665 | 10 |
| 9. Northwestern University Medical School, Chicago | 132 | 532 | 664 | 9 |
| 10. Temple University School of Medicine, Philadelphia | 120 | 525 | 645 | ------------ |
| 11. University of Texas Medical Branch, Galveston, Tex | 126 | 513 | 639 | ------------ |
| 12. University of Tennessee College of Medicine, Memphis | 104 | 525 | 629 | 8 |
| Total | 1, 677 | 7, 432 | 9, 109 | ------------ |

Source: Journal of the American Medical Association, Dec. 29, 1975, v. 234, No. 13.

TABLE 71.—*Interns and residents by State location of school of medical education as of December 1974*

| State location of medical school | Interns | Residents | Total |
|---|---|---|---|
| Alabama | 75 | 296 | 371 |
| Arizona | 52 | 103 | 155 |
| Arkansas | 77 | 283 | 360 |
| California | 543 | 1, 989 | 2, 532 |
| Colorado | 82 | 353 | 435 |
| Connecticut | 84 | 345 | 429 |
| District of Columbia | 276 | 1, 145 | 1, 421 |
| Florida | 141 | 543 | 684 |
| Georgia | 169 | 632 | 801 |
| Hawaii | 1 | 0 | 1 |
| Illinois | 529 | 2, 359 | 2, 888 |
| Indiana | 166 | 685 | 851 |
| Iowa | 139 | 605 | 744 |
| Kansas | 81 | 463 | 544 |
| Kentucky | 152 | 558 | 710 |
| Louisiana | 219 | 924 | 1, 143 |
| Maine | 0 | 0 | 0 |
| Maryland | 170 | 846 | 1, 016 |
| Massachusetts | 350 | 1, 289 | 1, 639 |
| Michigan | 279 | 1, 082 | 1, 361 |
| Minnesota | 189 | 605 | 794 |
| Mississippi | 65 | 263 | 328 |
| Missouri | 267 | 1, 179 | 1, 446 |
| Nebraska | 135 | 618 | 753 |
| New Hampshire | 15 | 16 | 31 |
| New Jersey | 85 | 332 | 417 |
| New Mexico | 33 | 98 | 131 |
| New York | 990 | 4, 074 | 5, 064 |
| North Carolina | 178 | 806 | 984 |
| Ohio | 368 | 1, 467 | 1, 835 |
| Oklahoma | 93 | 366 | 459 |
| Oregon | 89 | 275 | 364 |
| Pennsylvania | 713 | 2, 882 | 3, 595 |
| Puerto Rico | 79 | 241 | 320 |
| South Carolina | 64 | 319 | 383 |
| Tennessee | 227 | 961 | 1, 188 |
| Texas | 470 | 1, 455 | 1, 925 |
| Utah | 52 | 225 | 277 |
| Vermont | 47 | 193 | 240 |
| Virginia | 152 | 708 | 860 |
| Washington | 69 | 340 | 409 |
| West Virginia | 51 | 219 | 270 |
| Wisconsin | 183 | 697 | 880 |
| Total | 8, 199 | 32, 839 | 41, 038 |

Source: "Journal of the American Medical Association," Dec. 29, 1975, vol. 234, No. 13.

TABLE 72.—*Physicians certified by specialty boards, as of Dec. 31, 1974* [1]

| | Graduates | | | | |
|---|---|---|---|---|---|
| | U.S. schools | Canadian schools | Foreign schools | Total certified | Percent foreign |
| American Board of— | | | | | |
| Allergy and Immunology | 944 | 11 | 100 | 1, 055 | 9. 5 |
| Anesthesiology | 4, 753 | 178 | 1, 289 | 6, 220 | 20. 7 |
| Colon and Rectal Surgery | 344 | 16 | 57 | 417 | 13. 7 |
| Dermatology | 2, 867 | 55 | 202 | 3, 121 | 6. 5 |
| Family Practice | 5, 618 | 78 | 380 | [2] 7, 018 | 5. 1 |
| Internal Medicine | 27, 404 | 330 | 2, 282 | [3] 30, 016 | 7. 6 |
| Neurological Surgery | 1, 430 | 51 | 154 | 1, 635 | 9. 4 |
| Nuclear Medicine | 1, 310 | 32 | 247 | 1, 589 | 15. 5 |
| Obstetrics Gynecology | 11, 106 | 234 | 1, 143 | 12, 483 | 9. 1 |
| Ophthalmology | 6, 766 | 156 | 441 | 7, 363 | 5. 9 |
| Orthopaedic Surgery | 7, 327 | 188 | 529 | 8, 044 | 6. 6 |
| Otolaryngology | 4, 508 | 127 | 376 | 5, 011 | 7. 5 |
| Pathology | 6, 236 | 209 | 2, 091 | 8, 586 | 24. 5 |
| Pediatrics | 12, 441 | 236 | 2, 297 | 14, 976 | 15. 3 |
| Physical Medicine and Rehabilitation | 643 | 19 | 256 | 918 | 27. 9 |
| Plastic Surgery | 1, 132 | 29 | 122 | 1, 283 | 9. 5 |
| Preventive Medicine | 2, 231 | 51 | 104 | 2, 386 | 4. 3 |
| Psychiatry and Neurology | 9, 779 | 350 | 1, 486 | 11, 615 | 12. 8 |
| Radiology | 10, 081 | 197 | 1, 270 | 11, 498 | 11. 0 |
| Surgery | 16, 332 | 298 | 1, 863 | 18, 493 | 10. 1 |
| Thoracic Surgery | 2, 318 | 46 | 378 | 2, 742 | 13. 8 |
| Urology | 3, 703 | 66 | 318 | 4, 087 | 7. 8 |
| Total | 139, 223 | 2, 959 | 17, 365 | 160, 509 | 10. 8 |

[1] Compiled from the physicians records of the American Medical Association, and prepared by the department of graduate medical education.

[2] Includes net increase of 1,288 by end of 1974 on certifications not reported until 1975.

[3] Includes net increase of 2,797 by end of 1974 on certifications not reported until 1975.

Source: Journal of the American Medical Association, Dec. 29, 1975, Vol. 234, No. 13.

## II. Nursing Professions

### A. DATA ON REGISTERED NURSES

TABLE 73.—*Registered nurses in relation to population, selected years, 1960–74*

| Year [1] | Resident population (thousands) [1] | Number of nurses in practice | | | Nurses per 100,000 population |
|---|---|---|---|---|---|
| | | Total | Full time | Part time | |
| 1974 [2] | 210, 674 | 857, 000 | 608, 000 | 249, 000 | 407 |
| 1973 [3] | 209, 118 | 815, 000 | 578, 000 | 237, 000 | 390 |
| 1972 [3] | 207, 364 | 780, 000 | 548, 000 | 232, 000 | 376 |
| 1971 [3] | 205, 056 | 750, 000 | 534, 000 | 216, 000 | 366 |
| 1970 [3] | 202, 617 | 722, 000 | 519, 000 | 203, 000 | 356 |
| 1969 [3] | 200, 985 | 694, 000 | 503, 000 | 191, 000 | 345 |
| 1968 [3] | 199, 017 | 667, 000 | 489, 000 | 178, 000 | 335 |
| 1967 [3] | 196, 858 | 643, 000 | 476, 000 | 167, 900 | 327 |
| 1966 | 194, 899 | 621, 000 | 466, 000 | 155, 000 | 319 |
| 1964 | 190, 169 | 582, 000 | 450, 000 | 132, 000 | 306 |
| 1962 | 184, 598 | 550, 000 | 433, 000 | 117, 000 | 298 |
| 1960 | 178, 729 | 504, 000 | 414, 000 | 90, 000 | 282 |

[1] As of Jan. 1.

[2] Preliminary.

[3] Revised estimates.

Sources: Interagency Conference on Nursing Statistics. U.S. Bureau of the Census, Population estimates, "Current Population Reports," Series P–25, No. 525. Also, prior reports.

Table 74.—*Estimated number of employed registered nurses, by educational preparation, selected years 1964–74, and projected need 1980*

| Year | Total | Diploma |  | Associate degree |  | Baccalaureate |  | Master's or above |  |
|---|---|---|---|---|---|---|---|---|---|
|  |  | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| 1980 need | 1, 100, 000 | 660, 000 | 60. 0 | (1) | (1) | 308, 000 | 28. 0 | 132, 000 | 12. 0 |
| 1974 | 857, 000 | 647, 000 | 75. 5 | 51, 600 | 6. 0 | 130, 400 | 15. 2 | 28, 000 | 3. 3 |
| 1973 | 815, 000 | 627, 500 | 77. 0 | 43, 200 | 5. 3 | 118, 200 | 14. 5 | 26, 100 | 3. 2 |
| 1972 | 780, 000 | 613, 400 | 78. 6 | 35, 200 | 4. 5 | 107, 200 | 13. 8 | 24, 200 | 3. 1 |
| 1971 | 750, 000 | 603, 100 | 80. 4 | 27, 800 | 3. 7 | 96, 600 | 12. 9 | 22, 500 | 3. 0 |
| 1970 [2] | 722, 000 | 593, 400 | 82. 2 | 21, 400 | 3. 0 | 87, 000 | 12. 0 | 20, 300 | 2. 8 |
| 1969 [2] | 694, 000 | 579, 900 | 83. 6 | 17, 000 | 2. 4 | 78, 400 | 11. 3 | 18, 700 | 2. 7 |
| 1968 [2] | 667, 000 | 566, 000 | 84. 9 | 12, 000 | 1. 8 | 72, 000 | 10. 8 | 17, 000 | 2. 5 |
| 1967 [2] | 643, 000 | 548, 700 | 85. 3 | 10, 000 | 1. 6 | 68, 200 | 10. 6 | 16, 100 | 2. 5 |
| 1966 | 621, 000 | 533, 200 | 85. 8 | 8, 000 | 1. 3 | 64, 500 | 10. 4 | 15, 300 | 2. 5 |
| 1964 | 582, 000 | 516, 600 | 88. 8 | (1) | (1) | 52, 100 | 8. 9 | 13, 300 | 2. 3 |

[1] For 1980 and 1964 nurses with associate degrees as their highest educational preparation are included with diploma.
[2] Estimates revised 1974.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Division of Nursing, Source Book of Nursing Personnel, DHEW Publication No. (HRA) 75–43, revised 1974, p. 69; Interagency Conference on Nursing Statistics for total estimates, 1964–74.

Table 75.—*Educational preparation of registered nurses in various fields of employment—1970 (includes 50 States and District of Columbia)*

| Field of employment | Total | Master's or doctoral degree | Baccalaureate | Associate degree | Nursing diploma |
|---|---|---|---|---|---|
| NUMBER | | | | | |
| Total | 700, 000 | 19, 000 | 80, 000 | 22, 000 | 579, 000 |
| Hospitals | 446, 000 | 3, 800 | 40, 000 | 14, 000 | 388, 200 |
| Nursing homes | 40, 000 | 500 | 3, 500 | 3, 100 | 32, 900 |
| Public health and school | 51, 000 | 3, 100 | 17, 500 | 400 | 30, 000 |
| Nursing education | 31, 000 | 11, 000 | 13, 000 | 300 | 6, 700 |
| Occupational health | 20, 000 | 200 | 1, 400 | 500 | 17, 900 |
| Private duty, office nurse, and other | 112, 000 | 400 | 4, 600 | 3, 700 | 103, 300 |
| PERCENT | | | | | |
| Total | 100. 0 | 2. 7 | 11. 4 | 3. 2 | 82. 7 |
| Hospitals | 100. 0 | . 9 | 9. 0 | 3. 1 | 87. 0 |
| Nursing homes | 100. 0 | 1. 2 | 8. 8 | 7. 8 | 82. 2 |
| Public health and school | 100. 0 | 6. 1 | 34. 3 | . 8 | 58. 8 |
| Nursing education | 100. 0 | 35. 5 | 41. 9 | 1. 0 | 21. 6 |
| Occupational health | 100. 0 | 1. 0 | 7. 0 | 2. 5 | 89. 5 |
| Private duty, office nurse, and other | 100. 0 | . 4 | 4. 1 | 3. 3 | 92. 2 |

Source: Total numbers and field of employment estimated by Interagency Conference on Nursing Statistics; educational preparation by Division of Nursing, U.S. Department of Health, Education, and Welfare, Public Health Service, Bureau of Health, Manpower, Education.

Table 76.—*Field of employment of registered nurses, Jan. 1, 1972*

| Field of employment | Number of nurses | Percent of total |
|---|---|---|
| Total | [1] 748, 000 | 100. 0 |
| Hospitals and nursing homes | 526, 000 | 70. 3 |
| Public health and school | 54, 000 | 7. 2 |
| Nursing education | 35, 000 | 4. 7 |
| Occupational health | 20, 000 | 2. 7 |
| Private duty, doctor's office, and other fields | 113, 000 | 15. 1 |

[1] Preliminary estimate.

Source: Division of Nursing, Bureau of Health Manpower Education, National Institutes of Health. In: "Health Resources Statistics, 1972–73." DHEW, 1973.

TABLE 77.—*Location of full-time registered nurses employed in hospitals in relation to hospital beds, 1973*

| Location | Hospital beds | Registered nurses (full time) | Registered nurses per 1,000 beds |
|---|---|---|---|
| United States | 1, 449, 062 | 379, 749 | 262 |
| Alabama | 24, 937 | 5, 021 | 201 |
| Alaska | 1, 608 | 537 | 334 |
| Arizona | 10, 891 | 4, 342 | 399 |
| Arkansas | 11, 875 | 2, 462 | 207 |
| California | 111, 887 | 38, 316 | 342 |
| Colorado | 15, 004 | 4, 967 | 331 |
| Connecticut | 19, 147 | 5, 644 | 295 |
| Delaware | 4, 315 | 1, 119 | 259 |
| District of Columbia | 11, 666 | 3, 109 | 267 |
| Florida | 50, 629 | 14, 324 | 283 |
| Georgia | 33, 188 | 7, 046 | 212 |
| Hawaii | 4, 519 | 1, 678 | 371 |
| Idaho | 3, 718 | 1, 064 | 286 |
| Illinois | 75, 883 | 22, 073 | 291 |
| Indiana | 33, 140 | 7, 268 | 219 |
| Iowa | 19, 986 | 4, 999 | 250 |
| Kansas | 17, 201 | 3, 899 | 227 |
| Kentucky | 20, 087 | 4, 804 | 239 |
| Louisiana | 25, 327 | 5, 017 | 198 |
| Maine | 7, 350 | 1, 888 | 257 |
| Maryland | 26, 166 | 6, 835 | 261 |
| Massachusetts | 51, 344 | 15, 805 | 308 |
| Michigan | 53, 916 | 14, 569 | 270 |
| Minnesota | 29, 613 | 7, 699 | 260 |
| Mississippi | 17, 838 | 2, 795 | 157 |
| Missouri | 36, 453 | 8, 183 | 224 |
| Montana | 5, 707 | 1, 186 | 208 |
| Nebraska | 11, 301 | 2, 972 | 263 |
| Nevada | 3, 256 | 934 | 287 |
| New Hampshire | 5, 604 | 1, 319 | 235 |
| New Jersey | 49, 012 | 12, 268 | 250 |
| New Mexico | 6, 225 | 1, 630 | 262 |
| New York | 158, 600 | 45, 288 | 286 |
| North Carolina | 32, 974 | 8, 420 | 255 |
| North Dakota | 5, 501 | 1, 264 | 230 |
| Ohio | 70, 900 | 17, 516 | 247 |
| Oklahoma | 17, 141 | 3, 379 | 197 |
| Oregon | 12, 114 | 4, 028 | 333 |
| Pennsylvania | 97, 827 | 26, 504 | 271 |
| Rhode Island | 7, 997 | 1, 922 | 240 |
| South Carolina | 18, 885 | 3, 570 | 189 |
| South Dakota | 6, 315 | 1, 400 | 222 |
| Tennessee | 30, 975 | 6, 192 | 200 |
| Texas | 75, 886 | 16, 855 | 222 |
| Utah | 4, 811 | 1, 475 | 307 |
| Vermont | 3, 613 | 1, 012 | 280 |
| Virginia | 33, 522 | 7, 973 | 238 |
| Washington | 17, 554 | 6, 035 | 344 |
| West Virginia | 16, 424 | 3, 286 | 200 |
| Wisconsin | 36, 444 | 7, 251 | 199 |
| Wyoming | 2, 786 | 607 | 218 |

Source: Unpublished data from the National Center for Health Statistics master facility census.

### TABLE 78.—*Location of full-time registered nurses in nursing and related homes, 1973*

| Location | Beds in nursing and related homes | Registered nurses | Registered nurses per 1,000 beds |
|---|---|---|---|
| United States | 1, 327, 704 | 41, 181 | 31 |
| Alabama | 14, 844 | 298 | 20 |
| Alaska | 606 | 40 | 66 |
| Arizona | 6, 430 | 299 | 47 |
| Arkansas | 17, 952 | 301 | 17 |
| California | 150, 956 | 4, 400 | 29 |
| Colorado | 16, 670 | 725 | 44 |
| Connecticut | 23, 294 | 1, 336 | 57 |
| Delaware | 2, 213 | 107 | 48 |
| District of Columbia | 3, 147 | 91 | 29 |
| Florida | 34, 956 | 1, 372 | 39 |
| Georgia | 25, 936 | 573 | 22 |
| Hawaii | 2, 726 | 157 | 58 |
| Idaho | 4, 190 | 153 | 37 |
| Illinois | 80, 151 | 2, 046 | 25 |
| Indiana | 34, 247 | 955 | 28 |
| Iowa | 35, 152 | 709 | 20 |
| Kansas | 22, 889 | 407 | 18 |
| Kentucky | 18, 177 | 308 | 17 |
| Louisiana | 17, 004 | 340 | 20 |
| Maine | 9, 227 | 319 | 35 |
| Maryland | 17, 755 | 367 | 37 |
| Massachusetts | 53, 858 | 2, 327 | 42 |
| Michigan | 48, 567 | 1, 373 | 28 |
| Minnesota | 44, 661 | 1, 178 | 27 |
| Mississippi | 7, 886 | 196 | 25 |
| Missouri | 33, 644 | 736 | 22 |
| Montana | 4, 759 | 209 | 44 |
| Nebraska | 17, 396 | 338 | 20 |
| Nevada | 1, 482 | 75 | 51 |
| New Hampshire | 5, 873 | 350 | 60 |
| New Jersey | 34, 430 | 1, 822 | 53 |
| New Mexico | 3, 345 | 96 | 30 |
| New York | 92, 888 | 4, 697 | 51 |
| North Carolina | 22, 145 | 564 | 25 |
| North Dakota | 6, 631 | 178 | 27 |
| Ohio | 65, 134 | 1, 879 | 29 |
| Oklahoma | 29, 512 | 427 | 15 |
| Oregon | 18, 306 | 587 | 32 |
| Pennsylvania | 65, 963 | 3, 156 | 48 |
| Rhode Island | 6, 493 | 232 | 36 |
| South Carolina | 8, 131 | 289 | 36 |
| South Dakota | 7, 795 | 203 | 26 |
| Tennessee | 14, 827 | 251 | 17 |
| Texas | 80, 510 | 957 | 12 |
| Utah | 4, 556 | 103 | 23 |
| Vermont | 3, 902 | 228 | 58 |
| Virginia | 16, 732 | 493 | 30 |
| Washington | 31, 147 | 1, 143 | 37 |
| West Virginia | 4, 753 | 151 | 31 |
| Wisconsin | 51, 960 | 1, 304 | 25 |
| Wyoming | 1, 896 | 66 | 35 |

Source: National Center for Health Statistics, Division of Health Manpower and Facilities Statistics, data collected in the 1973 master facility inventory survey of inpatient health facilities.

TABLE 79.—*Schools of nursing—registered nurses and number of students and graduates by type of program: selected years, 1960–61 through 1974–75*

| Academic year [1] | Schools | Students [2] | Graduates | | | |
|---|---|---|---|---|---|---|
| | | | Total | Diploma | Associate degree | Bachelor's degree |
| 1974–75 | 1, 359 | 244, 486 | | | | |
| 1973–74 | 1, 359 | 232, 589 | 67, 628 | 21, 280 | 29, 299 | 17, 049 |
| 1972–73 | 1, 363 | 213, 127 | 59, 427 | 21, 445 | 24, 850 | 13, 132 |
| 1971–72 | 1, 350 | 187, 551 | 51, 784 | 21, 592 | 19, 165 | 11, 027 |
| 1970–71 | 1, 343 | 164, 545 | 47, 001 | 22, 334 | 14, 754 | 9, 913 |
| 1969–70 | 1, 328 | 150, 795 | 43, 639 | 22, 856 | 11, 678 | 9, 105 |
| 1968–69 | 1, 287 | 145, 588 | 42, 196 | 25, 114 | 8, 701 | [3] 8, 381 |
| 1967–68 | 2, 262 | 141, 948 | 41, 555 | 28, 197 | 6, 213 | [3] 7, 145 |
| 1966–67 | 1, 219 | 139, 070 | 38, 237 | 27, 452 | 4, 654 | [3] 6, 131 |
| 1965–66 | 1, 191 | 135, 702 | 35, 125 | 26, 278 | 3, 349 | [3] 5, 498 |
| 1964–65 | 1, 153 | 129, 269 | 34, 686 | 26, 795 | 2, 510 | [3] 5, 381 |
| 1962–63 | 1, 128 | 123, 861 | 32, 398 | 26, 438 | 1, 479 | 4, 481 |
| 1960–61 | 1, 123 | 118, 849 | 30, 267 | 25, 311 | 917 | 4, 039 |

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[1] Includes Puerto Rico for all years, the Virgin Islands for 1965–66 through 1972–73, and Guam for 1966–77 through 1974–75.

[2] Fall enrollment at beginning of academic year.

[3] Includes students in 1 basic program that gives a master's degree.

Source: National League for Nursing: "State-Approved Schools of Nursing—R.N.,' New York, 1975, Published annually.

TABLE 80.—*Locations of schools of nursing—registered nurses and number of students and graduates, 1974*

| Location | Schools [1] | Students [1] | Graduates [2] | | | |
|---|---|---|---|---|---|---|
| | | | Total | Diploma | Associate degree | Bachelor's degree |
| All locations | 1, 359 | 244, 486 | 67, 628 | 21, 280 | 29, 299 | 17, 049 |
| United States | 1, 347 | 242, 551 | 67, 061 | 21, 185 | 28, 919 | 16, 957 |
| Alabama | 30 | 4, 732 | 996 | 430 | 351 | 215 |
| Alaska | 2 | 168 | 46 | ---------- | 27 | 19 |
| Arizona | 15 | 2, 988 | 709 | ---------- | 448 | 261 |
| Arkansas | 9 | 1, 503 | 508 | ---------- | 436 | 72 |
| California | 83 | 12, 221 | 4, 453 | 422 | 2, 895 | 1, 136 |
| Colorado | 11 | 2, 120 | 574 | 83 | 301 | 190 |
| Connecticut | 25 | 3, 930 | 1, 016 | 604 | 173 | 239 |
| Delaware | 7 | 1, 215 | 209 | 99 | 18 | 92 |
| District of Columbia | 7 | 1, 508 | 382 | 56 | 131 | 195 |
| Florida | 27 | 5, 431 | 1, 926 | 95 | 1, 429 | 402 |
| Georgia | 31 | 4, 653 | 1, 288 | 262 | 778 | 248 |
| Hawaii | 4 | 361 | 153 | ---------- | 92 | 61 |
| Idaho | 6 | 638 | 247 | ---------- | 214 | 33 |
| Illinois | 80 | 13, 004 | 3, 499 | 1, 419 | 1, 452 | 628 |
| Indiana | 27 | 6, 736 | 1, 682 | 429 | 808 | 445 |
| Iowa | 30 | 3, 834 | 1, 108 | 522 | 299 | 287 |
| Kansas | 22 | 2, 238 | 790 | 382 | 175 | 233 |
| Kentucky | 25 | 4, 076 | 1, 133 | 171 | 715 | 247 |
| Louisiana | 17 | 4, 260 | 679 | 212 | 205 | 262 |
| Maine | 9 | 1, 198 | 256 | 118 | 74 | 64 |
| Maryland | 23 | 4, 434 | 1, 319 | 278 | 645 | 396 |
| Massachusetts | 60 | 10, 534 | 2, 963 | 1, 427 | 941 | 595 |
| Michigan | 45 | 9, 011 | 2, 778 | 845 | 1, 308 | 625 |
| Minnesota | 26 | 5, 261 | 1, 862 | 525 | 767 | 570 |
| Mississippi | 19 | 2, 425 | 591 | 53 | 440 | 98 |
| Missouri | 34 | 5, 684 | 1, 711 | 876 | 517 | 318 |
| Montana | 5 | 1, 253 | 232 | 32 | 61 | 139 |
| Nebraska | 12 | 2, 433 | 828 | 522 | 151 | 155 |
| Nevada | 3 | 655 | 124 | ---------- | 86 | 38 |
| New Hampshire | 9 | 1, 259 | 284 | 146 | 43 | 95 |
| New Jersey | 41 | 7, 425 | 1, 818 | 764 | 802 | 252 |
| New Mexico | 7 | 779 | 195 | ---------- | 133 | 62 |
| New York | 122 | 31, 597 | 8, 204 | 2, 434 | 3, 979 | 1, 791 |
| North Carolina | 48 | 5, 918 | 1, 528 | 394 | 608 | 526 |
| North Dakota | 9 | 1, 270 | 415 | 130 | 119 | 166 |
| Ohio | 71 | 12, 468 | 3, 745 | 1, 816 | 1, 231 | 698 |
| Oklahoma | 18 | 2, 256 | 572 | 128 | 240 | 204 |
| Oregon | 12 | 1, 912 | 598 | 154 | 262 | 182 |
| Pennsylvania | 110 | 15, 759 | 4, 749 | 3, 171 | 741 | 837 |
| Rhode Island | 7 | 1, 709 | 431 | 69 | 206 | 156 |
| South Carolina | 12 | 2, 373 | 593 | 118 | 352 | 123 |
| South Dakota | 10 | 1, 516 | 419 | 118 | 130 | 171 |
| Tennessee | 26 | 5, 552 | 1, 261 | 322 | 668 | 271 |
| Texas | 42 | 12, 397 | 2, 736 | 333 | 1, 241 | 1, 162 |
| Utah | 4 | 985 | 517 | ---------- | 293 | 224 |
| Vermont | 3 | 678 | 176 | ---------- | 116 | 60 |
| Virginia | 40 | 4, 687 | 1, 344 | 503 | 501 | 340 |
| Washington | 22 | 4, 366 | 1, 190 | 85 | 597 | 508 |
| West Virginia | 16 | 2, 268 | 698 | 152 | 427 | 119 |
| Wisconsin | 22 | 6, 566 | 1, 461 | 486 | 267 | 708 |
| Wyoming | 2 | 307 | 65 | ---------- | 26 | 39 |
| Guam | 1 | 89 | 11 | ---------- | 11 | ---------- |
| Puerto Rico | 10 | 1, 794 | 544 | 95 | 357 | 92 |
| Virgin Islands | 1 | 52 | 12 | ---------- | 12 | ---------- |

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[1] As of Oct. 15, 1972.

[2] Includes 1,504 graduates from 43 programs closed during academic year 1971–72.

Source: National League for Nursing: "State-Approved Schools of Nursing—R.N.," New York, 1975. Published annually.

## B. DATA ON PRACTICAL NURSES

TABLE 81.—*Practical nurses in relation to population, selected years, 1950–74*

| Year [1] | Resident population in thousands | Number of nurses in practice | | Nurses per 100,000 population |
|---|---|---|---|---|
| | | Total | In AHA registered hospitals | |
| 1974 | 210, 674 | 492, 000 | | 234 |
| 1973 | 209, 118 | 459, 000 | | 219 |
| 1972 | 207, 361 | 427, 000 | 237, 346 | 195 |
| 1971 | 205, 050 | 400, 000 | | 182 |
| 1970 | 203, 145 | 370, 000 | 221, 935 | 172 |
| 1968 | 199, 017 | 320, 000 | 185, 391 | 161 |
| 1966 | 194, 899 | 282, 000 | 151, 000 | 145 |
| 1964 | 190, 169 | 250, 000 | 128, 800 | 131 |
| 1962 | 184, 598 | 225, 000 | 126, 825 | 122 |
| 1960 | 179, 323 | 206, 000 | | 115 |
| 1950 | 151, 326 | 137, 500 | 49, 800 | 91 |

[1] As of Jan. 1.

Source: U.S. Public Health Service, Division of Nursing's estimates of practical nurses employed 1962, U.S. Bureau of the Census data for 1950 and 1960. U.S. Bureau of the Census, population estimates, "Current Population Reports." Series P–25, No. 525. Also, prior reports.

TABLE 82.—*Location of licensed practical nurses according to activity status and ratio to population: 1967*

| Location | Number of nurses | | | | | Employed nurses per 100,000 population (adjusted) |
|---|---|---|---|---|---|---|
| | Total | Employed in nursing | Not employed in nursing | Activity status not reported | Employed in nursing (adjusted) [1] | |
| United States | 343, 635 | 252, 522 | 69, 189 | 21, 924 | 269, 523 | 135 |
| Alabama | 5, 271 | 4, 263 | 805 | 203 | 4, 437 | 125 |
| Alaska | 285 | 198 | 86 | 1 | 199 | 73 |
| Arizona | 2, 221 | 1, 709 | 478 | 34 | 1, 737 | 104 |
| Arkansas | 4, 128 | 3, 360 | 664 | 104 | 3, 448 | 176 |
| California | 26, 203 | 18, 479 | 5, 626 | 2, 098 | 20, 091 | 103 |
| Colorado | 4, 510 | 3, 657 | 809 | 44 | 3, 696 | 181 |
| Connecticut | 4, 386 | 3, 549 | 683 | 154 | 3, 677 | 125 |
| Delaware | 803 | 640 | 149 | 14 | 650 | 125 |
| District of Columbia | 2, 431 | 2, 090 | 259 | 82 | 2, 162 | 267 |
| Florida | 11, 625 | 8, 753 | 1, 674 | 1, 198 | 9, 747 | 158 |
| Georgia | 4, 987 | 3, 801 | 1, 046 | 140 | 3, 912 | 88 |
| Hawaii | 1, 588 | 1, 203 | 244 | 141 | 1, 319 | 176 |
| Idaho | 1, 957 | 1, 439 | 510 | 8 | 1, 445 | 205 |
| Illinois | 14, 571 | 11, 150 | 2, 231 | 1, 190 | 12, 146 | 111 |
| Indiana | 3, 885 | 2, 997 | 620 | 268 | 3, 222 | 64 |
| Iowa | 3, 335 | 2, 373 | 876 | 86 | 2, 440 | 87 |
| Kansas | 2, 422 | 1, 801 | 503 | 118 | 1, 897 | 83 |
| Kentucky | 3, 621 | 2, 787 | 666 | 168 | 2, 924 | 92 |
| Louisiana | 6, 322 | 5, 032 | 1, 248 | 42 | 5, 067 | 138 |
| Maine | 1, 037 | 655 | 327 | 55 | 691 | 70 |
| Maryland | 3, 990 | 3, 025 | 912 | 53 | 3, 005 | 82 |
| Massachusetts | 16, 633 | 9, 532 | 3, 176 | 3, 925 | 12, 409 | 228 |
| Michigan | 16, 122 | 10, 781 | 3, 778 | 1, 563 | 11, 948 | 140 |
| Minnesota | 6, 226 | 4, 964 | 1, 158 | 104 | 5, 053 | 139 |
| Mississippi | 3, 579 | 2, 912 | 533 | 134 | 3, 029 | 130 |
| Missouri | 7, 901 | 6, 490 | 1, 032 | 379 | 6, 819 | 149 |
| Montana | 812 | 587 | 221 | 4 | 591 | 82 |
| Nebraska | 1, 528 | 1, 144 | 348 | 36 | 1, 172 | 79 |
| Nevada | 802 | 544 | 246 | 12 | 552 | 116 |
| New Hampshire | 1, 436 | 932 | 388 | 116 | 1, 011 | 151 |
| New Jersey | 11, 086 | 7, 464 | 2, 776 | 846 | 8, 081 | 115 |
| New Mexico | 1, 515 | 1, 116 | 307 | 92 | 1, 188 | 112 |
| New York | 34, 850 | 24, 961 | 9, 436 | 453 | 25, 293 | 139 |
| North Carolina | 6, 593 | 5, 229 | 1, 153 | 211 | 5, 407 | 108 |
| North Dakota | 766 | 603 | 160 | 3 | 606 | 94 |
| Ohio | 18, 368 | 14, 683 | 3, 307 | 378 | 14, 998 | 141 |
| Oklahoma | 4, 195 | 2, 973 | 713 | 509 | 3, 387 | 136 |
| Oregon | 3, 001 | 2, 164 | 818 | 19 | 2, 179 | 109 |
| Pennsylvania | 31, 747 | 23, 940 | 6, 878 | 929 | 24, 652 | 210 |
| Rhode Island | 2, 153 | 1, 585 | 505 | 63 | 1, 632 | 181 |
| South Carolina | 2, 676 | 2, 183 | 428 | 65 | 2, 239 | 85 |
| South Dakota | 817 | 614 | 159 | 44 | 651 | 92 |
| Tennessee | 6, 969 | 5, 669 | 1, 155 | 145 | 5, 793 | 149 |
| Texas | 30, 814 | 20, 237 | 5, 270 | 5, 307 | 24, 440 | 222 |
| Utah | 1, 551 | 1, 191 | 339 | 21 | 1, 207 | 116 |
| Vermont | 1, 279 | 935 | 316 | 28 | 956 | 236 |
| Virginia | 5, 859 | 4, 808 | 959 | 92 | 4, 884 | 107 |
| Washington | 7, 014 | 4, 757 | 2, 143 | 114 | 4, 835 | 155 |
| West Virginia | 2, 821 | 2, 317 | 406 | 98 | 2, 402 | 136 |
| Wisconsin | 4, 570 | 3, 969 | 573 | 28 | 3, 996 | 94 |
| Wyoming | 374 | 277 | 92 | 5 | 281 | 80 |

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[1] Adjusted for activity status not reported.

Sources: Marshall, E., and Moses, E.: "L.P.N.'s 1967: An Inventory of Licensed Practical Nurses." Division of Nursing, Bureau of Health Manpower Education, Public Health Service. U.S. Department of Health, Education, and Welfare. Washington, U.S. Government Printing Office, January 1971. In: "Health Resources Statistics, 1972–73." DHEW, 1973.

TABLE 83.—*Location of full-time licensed practical nurses employed in hospitals in relation to hospital beds: 1973*

| Location | Hospital beds | Licensed practical nurses (full time) | Licensed practical nurses per 1,000 beds |
|---|---|---|---|
| United States | 1, 449, 062 | 200, 940 | 139 |
| Alabama | 24, 937 | 4, 786 | 192 |
| Alaska | 1, 608 | 252 | 157 |
| Arizona | 10, 891 | 1, 715 | 157 |
| Arkansas | 11, 875 | 3, 041 | 256 |
| California | 111, 887 | 16, 776 | 150 |
| Colorado | 15, 004 | 1, 794 | 120 |
| Connecticut | 19, 147 | 2, 301 | 120 |
| Delaware | 4, 315 | 538 | 125 |
| District of Columbia | 11, 666 | 1, 634 | 140 |
| Florida | 50, 629 | 7, 111 | 140 |
| Georgia | 33, 188 | 5, 179 | 156 |
| Hawaii | 4, 519 | 1, 024 | 227 |
| Idaho | 3, 718 | 853 | 229 |
| Illinois | 75, 883 | 8, 500 | 112 |
| Indiana | 33, 140 | 3, 349 | 101 |
| Iowa | 19, 986 | 2, 315 | 116 |
| Kansas | 17, 201 | 2, 051 | 119 |
| Kentucky | 20, 087 | 3, 234 | 161 |
| Louisiana | 25, 327 | 3, 857 | 152 |
| Maine | 7, 350 | 927 | 126 |
| Maryland | 26, 166 | 2, 976 | 114 |
| Massachusetts | 51, 344 | 6, 544 | 127 |
| Michigan | 53, 916 | 8, 610 | 160 |
| Minnesota | 29, 613 | 3, 596 | 121 |
| Mississippi | 17, 838 | 2, 745 | 154 |
| Missouri | 36, 453 | 4, 817 | 132 |
| Montana | 5, 707 | 650 | 114 |
| Nebraska | 11, 301 | 1, 352 | 120 |
| Nevada | 3, 256 | 574 | 176 |
| New Hampshire | 5, 604 | 615 | 110 |
| New Jersey | 49, 012 | 5, 670 | 116 |
| New Mexico | 6, 225 | 975 | 157 |
| New York | 158, 600 | 16, 300 | 103 |
| North Carolina | 32, 974 | 4, 486 | 136 |
| North Dakota | 5, 501 | 673 | 122 |
| Ohio | 70, 900 | 11, 180 | 158 |
| Oklahoma | 17, 141 | 2, 742 | 160 |
| Oregon | 12, 114 | 1, 460 | 121 |
| Pennsylvania | 97, 827 | 11, 964 | 122 |
| Rhode Island | 7, 997 | 958 | 120 |
| South Carolina | 18, 885 | 2, 656 | 141 |
| South Dakota | 6, 315 | 596 | 94 |
| Tennessee | 30, 975 | 5, 685 | 184 |
| Texas | 75, 886 | 16, 216 | 214 |
| Utah | 4, 811 | 745 | 155 |
| Vermont | 3, 613 | 571 | 158 |
| Virginia | 33, 522 | 4, 986 | 149 |
| Washington | 17, 554 | 3, 270 | 186 |
| West Virginia | 16, 424 | 2, 291 | 139 |
| Wisconsin | 36, 444 | 3, 600 | 99 |
| Wyoming | 2, 786 | 200 | 72 |

Source: Unpublished data from the National Center for Health Statistics master facility census.

TABLE 84.—*Location of full-time licensed practical nurses in nursing and related homes: 1973*

| Location | Beds in nursing and related homes | Licensed practical nurses | Licensed practical nurses per 1,000 beds |
|---|---|---|---|
| United States | 1, 327, 704 | 55, 747 | 42 |
| Alabama | 14, 844 | 1, 141 | 77 |
| Alaska | 606 | 23 | 38 |
| Arizona | 6, 430 | 197 | 31 |
| Arkansas | 17, 952 | 830 | 47 |
| California | 150, 956 | 5, 180 | 35 |
| Colorado | 16, 670 | 806 | 48 |
| Connecticut | 23, 294 | 874 | 38 |
| Delaware | 2, 213 | 65 | 29 |
| District of Columbia | 3, 147 | 147 | 47 |
| Florida | 34, 956 | 1, 753 | 58 |
| Georgia | 25, 936 | 1, 513 | 58 |
| Hawaii | 2, 726 | 175 | 64 |
| Idaho | 4, 190 | 196 | 47 |
| Illinois | 80, 151 | 2, 687 | 34 |
| Indiana | 34, 247 | 927 | 26 |
| Iowa | 35, 152 | 999 | 29 |
| Kansas | 22, 889 | 414 | 18 |
| Kentucky | 18, 177 | 546 | 30 |
| Louisiana | 17, 004 | 940 | 58 |
| Maine | 9, 227 | 329 | 35 |
| Maryland | 17, 755 | 682 | 39 |
| Massachusetts | 53, 858 | 2, 687 | 50 |
| Michigan | 48, 567 | 1, 862 | 39 |
| Minnesota | 44, 661 | 1, 222 | 27 |
| Mississippi | 7, 886 | 536 | 68 |
| Missouri | 33, 644 | 1, 222 | 37 |
| Montana | 4, 759 | 201 | 43 |
| Nebraska | 17, 396 | 407 | 24 |
| Nevada | 1, 482 | 87 | 59 |
| New Hampshire | 5, 873 | 220 | 37 |
| New Jersey | 34, 430 | 1, 286 | 37 |
| New Mexico | 3, 345 | 154 | 47 |
| New York | 92, 888 | 4, 999 | 55 |
| North Carolina | 22, 145 | 793 | 36 |
| North Dakota | 6, 631 | 133 | 20 |
| Ohio | 65, 134 | 4, 012 | 61 |
| Oklahoma | 29, 512 | 1, 141 | 39 |
| Oregon | 18, 306 | 415 | 22 |
| Pennsylvania | 65, 963 | 3, 779 | 57 |
| Rhode Island | 6, 493 | 229 | 36 |
| South Carolina | 8, 131 | 401 | 50 |
| South Dakota | 7, 795 | 152 | 19 |
| Tennessee | 14, 827 | 806 | 54 |
| Texas | 80, 510 | 4, 875 | 61 |
| Utah | 4, 556 | 211 | 47 |
| Vermont | 3, 902 | 253 | 65 |
| Virginia | 16, 732 | 740 | 42 |
| Washington | 31, 147 | 949 | 30 |
| West Virginia | 4, 753 | 232 | 49 |
| Wisconsin | 51, 960 | 1, 257 | 24 |
| Wyoming | 1, 896 | 62 | 33 |

Source: National Center for Health Statistics, Division of Health Manpower and Facilities Statistics—data collected in the 1973 master facility inventory survey of inpatient health facilities.

**TABLE 85.**—*Licensed practical nurses, employed in nursing, by field of employment, 1967*

| State | Total | Field of employment | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Hospital | Nursing home | Private nursing | Public health | Industry | Other | Other specified field | Not reported |
| Total number | 252, 522 | 166, 483 | 29, 807 | 34, 588 | 3, 139 | 1, 007 | 14, 466 | 657 | 2, 375 |
| Percent | 100. 0 | 65. 9 | 11. 8 | 13. 7 | 1. 3 | . 4 | 5. 7 | . 3 | . 9 |
| Alabama | 4, 263 | 2, 821 | 639 | 473 | 9 | 16 | 293 | 1 | 11 |
| Alaska | 198 | 137 | 5 | 4 | 41 | --------- | 5 | 2 | 4 |
| Arizona | 1, 709 | 1, 160 | 110 | 266 | 52 | 1 | 89 | 27 | 4 |
| Arkansas | 3, 360 | 2, 273 | 319 | 392 | 48 | 27 | 280 | 8 | 13 |
| California | 18, 479 | 13, 175 | 1, 981 | 1, 579 | 197 | 63 | 1, 285 | 89 | 110 |
| Colorado | 3, 657 | 2, 079 | 867 | 412 | 36 | 2 | 187 | 42 | 32 |
| Connecticut | 3, 549 | 1, 985 | 895 | 372 | 44 | 17 | 167 | 6 | 63 |
| Delaware | 640 | 373 | 60 | 149 | 15 | 3 | 33 | 1 | 6 |
| District of Columbia | 2, 090 | 1, 471 | 107 | 345 | 108 | 2 | 40 | 3 | 14 |
| Florida | 8, 753 | 5, 113 | 1, 092 | 1, 507 | 25 | 15 | 743 | 139 | 119 |
| Georgia | 3, 801 | 2, 210 | 485 | 580 | 58 | 25 | 421 | 5 | 17 |
| Hawaii | 1, 203 | 932 | 31 | 59 | 9 | 10 | 146 | --------- | 16 |
| Idaho | 1, 439 | 1, 048 | 204 | 48 | 31 | 2 | 100 | 4 | 2 |
| Illinois | 11, 150 | 7, 025 | 1, 731 | 1, 536 | 275 | 68 | 430 | 19 | 66 |
| Indiana | 2, 997 | 2, 058 | 333 | 352 | 22 | 25 | 184 | 3 | 20 |
| Iowa | 2, 373 | 1, 465 | 544 | 151 | 22 | 5 | 169 | 1 | 16 |
| Kansas | 1, 801 | 1, 297 | 188 | 206 | 7 | 4 | 88 | 1 | 10 |
| Kentucky | 2, 787 | 1, 949 | 224 | 376 | 17 | 27 | 182 | 4 | 8 |
| Louisiana | 5, 032 | 2, 914 | 579 | 1, 040 | 51 | 11 | 415 | 9 | 13 |
| Maine | 655 | 469 | 87 | 61 | 4 | --------- | 23 | 2 | 9 |
| Maryland | 3, 025 | 2, 260 | 188 | 392 | 36 | 15 | 113 | 5 | 16 |
| Massachusetts | 9, 532 | 5, 790 | 2, 200 | 975 | 172 | 55 | 143 | 17 | 180 |
| Michigan | 10, 781 | 8, 365 | 853 | 428 | 124 | 60 | 865 | 12 | 74 |
| Minnesota | 4, 964 | 3, 664 | 665 | 203 | 48 | 11 | 354 | 4 | 15 |
| Mississippi | 2, 912 | 1, 920 | 141 | 412 | 20 | 11 | 212 | 5 | 191 |
| Missouri | 6, 490 | 4, 068 | 698 | 1, 217 | 51 | 39 | 346 | 14 | 57 |
| Montana | 587 | 429 | 75 | 37 | 16 | --------- | 26 | 2 | 2 |
| Nebraska | 1, 144 | 783 | 165 | 85 | 10 | 5 | 87 | 3 | 6 |
| Nevada | 544 | 430 | 31 | 24 | 3 | --------- | 52 | --------- | 4 |
| New Hampshire | 932 | 613 | 182 | 87 | 11 | 2 | 29 | 1 | 7 |
| New Jersey | 7, 464 | 4, 434 | 779 | 1, 743 | 56 | 25 | 272 | 8 | 147 |
| New Mexico | 1, 116 | 773 | 89 | 109 | 53 | --------- | 83 | 6 | 3 |
| New York | 24, 961 | 16, 202 | 3, 103 | 4, 197 | 449 | 93 | 748 | 59 | 105 |
| North Carolina | 5, 229 | 3, 491 | 305 | 902 | 12 | 13 | 420 | 8 | 78 |
| North Dakota | 603 | 478 | 65 | 8 | 6 | --------- | 39 | 1 | 6 |
| Ohio | 14, 683 | 8, 977 | 2, 083 | 2, 457 | 187 | 71 | 795 | 31 | 82 |
| Oklahoma | 2, 973 | 1, 845 | 439 | 361 | 62 | 15 | 223 | 5 | 23 |
| Oregon | 2, 164 | 1, 535 | 299 | 134 | 38 | 10 | 125 | 8 | 15 |
| Pennsylvania | 23, 940 | 16, 210 | 1, 486 | 4, 753 | 199 | 64 | 769 | 48 | 411 |
| Rhode Island | 1, 585 | 1, 153 | 198 | 120 | 30 | 17 | 53 | 5 | 9 |
| South Carolina | 2, 183 | 1, 429 | 192 | 275 | 21 | 12 | 158 | 5 | 91 |
| South Dakota | 614 | 419 | 98 | 12 | 20 | --------- | 62 | 1 | 2 |
| Tennessee | 5, 669 | 3, 863 | 324 | 891 | 61 | 56 | 454 | 3 | 17 |
| Texas | 20, 237 | 12, 682 | 2, 489 | 2, 912 | 217 | 37 | 1, 756 | 22 | 122 |
| Utah | 1, 191 | 880 | 133 | 50 | 5 | 1 | 113 | 1 | 8 |
| Vermont | 935 | 583 | 217 | 104 | 4 | --------- | 22 | 1 | 4 |
| Virginia | 4, 808 | 3, 241 | 360 | 780 | 65 | 15 | 299 | 5 | 43 |
| Washington | 4, 757 | 3, 192 | 823 | 402 | 32 | 13 | 200 | 3 | 92 |
| West Virginia | 2, 317 | 1, 618 | 90 | 340 | 18 | 8 | 141 | 3 | 9 |
| Wisconsin | 3, 969 | 3, 001 | 515 | 155 | 41 | 31 | 218 | 5 | 3 |
| Wyoming | 277 | 201 | 41 | 25 | 1 | --------- | 9 | --------- | --------- |

Source: ANA, Research and Statistics Department, 1967 inventory of licensed practical nurses. In: "Health Resources Statistics, 1972–73." DHEW, 1973.

TABLE 86.—*Programs of practical nurse training and number of admissions and graduates, selected years, 1961–62 through 1973–74*

| Academic year [1] | Approved programs [2] | Admissions | Graduates |
|---|---|---|---|
| 1973–74 | 1, 314 | 60, 249 | 45, 863 |
| 1972–73 | 1, 306 | 60, 475 | 46, 456 |
| 1971–72 | 1, 310 | 61, 680 | 44, 446 |
| 1970–71 | 1, 291 | 60, 057 | 38, 556 |
| 1969–70 | 1, 253 | 55, 635 | 37, 128 |
| 1968–69 | 1, 252 | 49, 107 | 34, 864 |
| 1967–68 | 1, 191 | 45, 076 | 30, 833 |
| 1966–67 | 1, 149 | 41, 269 | 27, 644 |
| 1965–66 | 1, 081 | 38, 755 | 25, 688 |
| 1964–65 | 984 | 36, 489 | 24, 331 |
| 1963–64 | 913 | 34, 131 | 22, 761 |
| 1961–62 | 739 | 26, 660 | 18, 106 |

[1] Includes American Samoa and the Virgin Islands for 1961–62 and succeeding years. Includes Puerto Rico for all years.

[2] Number of programs is as of Oct. 15; admissions and graduates are based on academic year and include those in programs that closed during the year.

Sources: American Nurses' Association: "Facts about Nursing: A Statistical Summary." New York, 1969. Also, prior issues. National League for Nursing: "State-Approved Schools of Nursing—L.P.N./L.V.N." New York, 1975. Also, prior issues.

TABLE 87.—*Location of programs of practical nursing and number of admissions and graduates: 1973–74*

| Location | Approved programs | Admissions [1] | Graduates [1] |
|---|---|---|---|
| All locations | 1, 315 | 60, 249 | 45, 863 |
| United States | 1, 294 | 59, 190 | 45, 002 |
| Alabama | 25 | 1, 215 | 799 |
| Alaska | 1 | 25 | 15 |
| Arizona | 12 | 382 | 367 |
| Arkansas | 22 | 902 | 614 |
| California | 99 | 4, 626 | 3, 279 |
| Colorado | 16 | 662 | 506 |
| Connecticut | 10 | 733 | 625 |
| Delaware | 4 | 159 | 104 |
| District of Columbia | 5 | 206 | 150 |
| Florida | 32 | 2, 179 | 1, 549 |
| Georgia | 55 | 2, 068 | 1, 308 |
| Hawaii | 3 | 112 | 74 |
| Idaho | 13 | 224 | 195 |
| Illinois | 41 | 2, 429 | 2, 030 |
| Indiana | 18 | 1, 162 | 994 |
| Iowa | 25 | 1, 026 | 978 |
| Kansas | 15 | 649 | 572 |
| Kentucky | 16 | 645 | 536 |
| Louisiana | 25 | 1, 322 | 925 |
| Maine | 5 | 210 | 198 |
| Maryland | 26 | 777 | 546 |
| Massachusetts | 36 | 1, 550 | 1, 321 |
| Michigan | 37 | 2, 570 | 1, 836 |
| Minnesota | 27 | 1, 262 | 1, 110 |
| Mississippi | 13 | 862 | 661 |
| Missouri | 33 | 1, 265 | 1, 004 |
| Montana | 7 | 250 | 231 |
| Nebraska | 9 | 547 | 490 |
| Nevada | 9 | 128 | 94 |
| New Hampshire | 4 | 163 | 117 |
| New Jersey | 41 | 1, 914 | 1, 326 |
| New Mexico | 10 | 249 | 201 |
| New York | 114 | 5, 247 | 3, 617 |
| North Carolina | 40 | 1, 448 | 1, 130 |
| North Dakota | 3 | 349 | 238 |
| Ohio | 42 | 2, 598 | 2, 231 |
| Oklahoma | 22 | 776 | 659 |
| Oregon | 12 | 270 | 344 |
| Pennsylvania | 52 | 3, 258 | 2, 428 |
| Rhode Island | 2 | 210 | 339 |
| South Carolina | 32 | 892 | 461 |
| South Dakota | 6 | 248 | 221 |
| Tennessee | 7 | 1, 290 | 968 |
| Texas | 142 | 5, 076 | 3, 773 |
| Utah | 6 | 355 | 230 |
| Vermont | 3 | 237 | 183 |
| Virginia | 60 | 1, 475 | 995 |
| Washington | 27 | 1, 170 | 916 |
| West Virginia | 14 | 486 | 410 |
| Wisconsin | 13 | 1, 241 | 1, 036 |
| Wyoming | 3 | 91 | 68 |
| American Samoa | 1 | 20 | 17 |
| Guam | 1 | --------------- | 25 |
| Puerto Rico | 19 | 1, 039 | 819 |

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[1] Admissions and graduates include those in an additional 46 programs that closed during the academic year.

Source: National League for Nursing: "State-Approved Schools of Nursing L.P.N./L.V.N." New York, June 1975. Published annually.

TABLE 88.—*Location of nursing aides, orderlies, and attendants employed in AHA hospitals in relation to hospital beds; 1970*

| Location | Aides, orderlies, and attendants | Aides, orderlies, and attendants per 1,000 beds |
|---|---|---|
| United States | [1] 559, 071 | 3, 562 |
| Alabama | 10, 312 | 3, 755 |
| Alaska | 517 | 2, 821 |
| Arizona | 4, 235 | 4, 419 |
| Arkansas | 4, 600 | 4, 122 |
| California | 42, 264 | 3, 305 |
| Colorado | 4, 909 | 3, 182 |
| Connecticut | 6, 729 | 3, 079 |
| Delaware | 1, 683 | 3, 286 |
| District of Columbia | 4, 513 | 3, 369 |
| Florida | 17, 310 | 3, 765 |
| Georgia | 13, 383 | 4, 156 |
| Hawaii | 1, 200 | 2, 223 |
| Idaho | 1, 044 | 2, 926 |
| Illinois | 33, 220 | 3, 586 |
| Indiana | 15, 157 | 4, 030 |
| Iowa | 9, 129 | 4, 222 |
| Kansas | 9, 577 | 5, 033 |
| Kentucky | 8, 693 | 4, 145 |
| Louisiana | 10, 778 | 4, 499 |
| Maine | 2, 887 | 3, 172 |
| Maryland | 11, 576 | 3, 661 |
| Massachusetts | 17, 406 | 2, 894 |
| Michigan | 23, 512 | 3, 675 |
| Minnesota | 12, 373 | 3, 787 |
| Mississippi | 6, 404 | 3, 863 |
| Missouri | 15, 520 | 4, 319 |
| Montana | 1, 928 | 4, 312 |
| Nebraska | 5, 776 | 4, 855 |
| Nevada | 1, 171 | 4, 329 |
| New Hampshire | 1, 830 | 2, 925 |
| New Jersey | 14, 871 | 2, 980 |
| New Mexico | 2, 509 | 4, 236 |
| New York | 65, 822 | 3, 582 |
| North Carolina | 11, 772 | 3, 588 |
| North Dakota | 3, 001 | 5, 157 |
| Ohio | 26, 584 | 3, 334 |
| Oklahoma | 8, 132 | 4, 837 |
| Oregon | 5, 417 | 4, 393 |
| Pennsylvania | 27, 675 | 2, 542 |
| Rhode Island | 2, 397 | 2, 901 |
| South Carolina | 5, 643 | 3, 045 |
| South Dakota | 2, 433 | 3, 897 |
| Tennessee | 11, 234 | 3, 645 |
| Texas | 26, 953 | 3, 596 |
| Utah | 1, 790 | 3, 571 |
| Vermont | 1, 044 | 2, 344 |
| Virginia | 12, 560 | 3, 207 |
| Washington | 5, 425 | 2, 853 |
| West Virginia | 5, 861 | 3, 673 |
| Wisconsin | 17, 168 | 4, 740 |
| Wyoming | 1, 144 | 3, 907 |

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[1] Includes full-time and part-time personnel in all departments of the hospital.

Source: Division of Nursing: "Nursing Personnel in Hospitals, 1970." Bureau of Health Manpower Education, Public Health Service, U.S. Department of Health, Education, and Welfare. Washington. U.S. Government Printing Office, 1972. (In press.) In: "Health Resources Statistics, 1972–73." DHEW, 1973.

## III. Dental Manpower

TABLE 89.—*Dentists in relation to population, selected years, Dec. 31, 1950, through 1973*

| | 1950 | 1960 | 1970 | 1973 |
|---|---|---|---|---|
| Active civilian dentists | 75, 310 | 84, 500 | 95, 680 | 100, 780 |
| Resident civilian population (thousands) | 151, 240 | 179, 740 | 203, 110 | 208, 094 |
| Active civilian dentists per 100,000 civilians | 49. 8 | 47. 0 | 47. 1 | 48 |

[1] State figures do not add to total due to rounding. Civilian populations as of July 1, 1973.

Sources: Division of Dentistry, Bureau of Health Manpower, Health Resources Administration, Department of Health, Education, and Welfare. U.S. Bureau of the Census: Population Estimates: "Current Population Reports," Series P–25, No. 508, November 1973.

TABLE 90.—*Distribution of dentists by State, region, and Federal dental service, 1972*

| Region and State | Total number of dentists, 1972 | Population per dentist | Number of 1972 graduates | Estimated population |
|---|---|---|---|---|
| New England | 7, 633 | 1, 584 | 170 | 12, 093, 100 |
| Connecticut | 2, 060 | 1, 505 | 24 | 3, 101, 000 |
| Maine | 469 | 2, 147 | 3 | 1, 006, 800 |
| Massachusetts | 4, 005 | 1, 445 | 122 | 5, 786, 000 |
| New Hampshire | 384 | 2, 010 | 5 | 771, 900 |
| Rhode Island | 484 | 1, 992 | 8 | 964, 000 |
| Vermont | 231 | 2, 006 | 8 | 463, 400 |
| Mideast | 29, 494 | 1, 519 | 636 | 44, 808, 400 |
| Delaware | 255 | 2, 204 | 9 | 562, 000 |
| District of Columbia | 646 | 1, 137 | 15 | 734, 600 |
| Maryland | 2, 039 | 1, 978 | 83 | 4, 032, 300 |
| New Jersey | 4, 488 | 1, 638 | 78 | 7, 353, 700 |
| New York | 14, 735 | 1, 252 | 284 | 18, 452, 200 |
| Pennsylvania | 6, 656 | 1, 791 | 148 | 11, 918, 600 |
| West Virginia | 675 | 2, 600 | 19 | 1, 755, 000 |
| Southeast | 17, 577 | 2, 452 | 436 | 43, 091, 300 |
| Alabama | 1, 173 | 2, 978 | 31 | 3, 493, 200 |
| Arkansas | 679 | 2, 881 | 9 | 1, 956, 500 |
| Florida | 4, 189 | 1, 705 | 35 | 7, 143, 600 |
| Georgia | 1, 690 | 2, 778 | 31 | 4, 694, 800 |
| Kentucky | 1, 279 | 2, 586 | 34 | 3, 307, 300 |
| Louisiana | 1, 451 | 2, 547 | 11 | 3, 696, 400 |
| Mississippi | 647 | 3, 446 | 13 | 2, 229, 500 |
| North Carolina | 1, 791 | 2, 887 | 64 | 5, 171, 400 |
| South Carolina | 808 | 3, 269 | 21 | 2, 641, 600 |
| Tennessee | 1, 813 | 2, 216 | 126 | 4, 016, 800 |
| Virginia | 2, 057 | 2, 304 | 61 | 4, 740, 200 |
| Southwest | 7, 261 | 2, 357 | 196 | 17, 112, 200 |
| Arizona | 951 | 1, 977 | 18 | 1, 880, 100 |
| New Mexico | 383 | 2, 704 | 11 | 1, 035, 500 |
| Oklahoma | 1, 063 | 2, 475 | 19 | 2, 630, 800 |
| Texas | 4, 864 | 2, 378 | 148 | 11, 565, 800 |

TABLE 90.—*Distribution of dentists by State, region, and Federal dental service, 1972*—Continued

| Region and State | Total number of dentists, 1972 | Population per dentist | Number of 1972 graduates | Estimated population |
|---|---|---|---|---|
| Central | 27, 705 | 1, 894 | 666 | 52, 460, 900 |
| Illinois | 6, 259 | 1, 794 | 156 | 11, 227, 800 |
| Indiana | 2, 341 | 2, 266 | 57 | 5, 305, 800 |
| Iowa | 1, 477 | 1, 938 | 31 | 2, 863, 000 |
| Michigan | 4, 741 | 1, 908 | 119 | 9, 045, 400 |
| Minnesota | 2, 686 | 1, 456 | 67 | 3, 911, 100 |
| Missouri | 2, 389 | 2, 000 | 86 | 4, 777, 600 |
| Ohio | 5, 210 | 2, 079 | 91 | 10, 830, 600 |
| Wisconsin | 2, 602 | 1, 729 | 59 | 4, 499, 600 |
| Northwest | 5, 689 | 1, 813 | 138 | 10, 311, 700 |
| Colorado | 1, 405 | 1, 647 | 29 | 2, 313, 900 |
| Idaho | 387 | 1, 911 | 7 | 739, 600 |
| Kansas | 1, 093 | 2, 069 | 32 | 2, 261, 500 |
| Montana | 393 | 1, 816 | 2 | 713, 600 |
| Nebraska | 967 | 1, 575 | 32 | 1, 523, 200 |
| North Dakota | 281 | 2, 234 | 5 | 627, 800 |
| South Dakota | 293 | 2, 299 | 10 | 673, 600 |
| Utah | 701 | 1, 591 | 18 | 1, 115, 300 |
| Wyoming | 169 | 2, 031 | 3 | 343, 200 |
| Far West | 18, 892 | 1, 461 | 467 | 27, 608, 700 |
| Alaska [1] | 125 | 2, 540 | 6 | 317, 500 |
| California | 14, 077 | 1, 444 | 372 | 20, 329, 900 |
| Hawaii | 534 | 1, 492 | 10 | 796, 600 |
| Nevada | 271 | 1, 898 | 6 | 514, 400 |
| Oregon | 1, 524 | 1, 434 | 26 | 2, 185, 400 |
| Washington | 2, 361 | 1, 468 | 47 | 3, 464, 900 |
| Total listed by State | 114, 251 | --- | 2, 709 | --- |
| Federal dental services | 9, 098 | --- | 1, 116 | --- |
| Air Force | 1, 996 | --- | 253 | --- |
| Army | 3, 094 | --- | 332 | --- |
| Navy | 2, 305 | --- | 408 | --- |
| Public Health Service | 783 | --- | 88 | --- |
| Veterans' Administration | 920 | --- | 35 | --- |
| United States total | 123, 349 | 1, 682 | 3, 825 | 207, 486, 300 |
| Outlying areas: | | | | |
| American Samoa | 1 | 27, 000 | 0 | 27, 000 |
| Guam | 15 | 5, 667 | 2 | 85, 000 |
| Mariana Islands | 1 | 10, 000 | 0 | 10, 000 |
| Panama Canal Zone | 16 | 2, 750 | 0 | 44, 000 |
| Puerto Rico | 610 | 4, 446 | 27 | 2, 712, 000 |
| Virgin Islands | 26 | 2, 385 | 0 | 62, 000 |

[1] A relatively high proportion of the Alaska population receives dental care from dentists counted in the "Federal dental services." Approximately 100 Federal dentists are located in Alaska. If they were included in the Alaska count, the Alaska population per dentist would be about 1,411.

Source: "Distribution of Dentists in the United States by State, Region, District, and County." ADA, 1973.

TABLE 91.—*Number of dental specialists, selected years, 1955 through 1972*

| Specialist | 1955 | 1960 | 1965 | 1970 | 1971 | 1972 |
|---|---|---|---|---|---|---|
| All specialists | 3, 034 | 4, 170 | 6, 462 | 10, 315 | 10, 697 | 11, 142 |
| Endodontists [1] | | | | 497 | 536 | 585 |
| Oral pathologists | 24 | 42 | 52 | 97 | 111 | 120 |
| Oral surgeons | 844 | 1, 183 | 1, 636 | 2, 406 | 2, 567 | 2, 714 |
| Orthodontists | 1, 521 | 2, 097 | 3, 437 | 4, 335 | 4, 415 | 4, 566 |
| Pedodontists | 148 | 229 | 568 | 1, 159 | 1, 195 | 1, 225 |
| Periodontists | 245 | 307 | 376 | 1, 003 | 1, 042 | 1, 114 |
| Prosthodontists | 225 | 278 | 336 | 715 | 715 | 702 |
| Public health dentists | 27 | 34 | 57 | 103 | 116 | 116 |

[1] Endodontics was not recognized as a dental specialty in 1955 or 1960, and data are unavailable for 1965.

Source: Bureau of Economic Research and Statistics: "Facts About States for the Dentists Seeking a Location, 1973," Chicago. American Dental Association. Also, prior annual issues.

TABLE 92.—*Dental schools, students, and graduates, selected years 1949–50 through 1973–74*

| Academic year | Schools | Students | Graduates |
|---|---|---|---|
| 1973–74 | 58 | 19, 369 | |
| 1972–73 | 56 | 18, 376 | 4, 230 |
| 1971–72 | 52 | 17, 305 | 3, 961 |
| 1970–71 | 53 | 16, 553 | 3, 775 |
| 1969–70 | 53 | 16, 008 | 3, 749 |
| 1968–69 | 52 | 15, 408 | 3, 433 |
| 1967–68 | 50 | 14, 955 | 3, 457 |
| 1966–67 | 49 | 14, 421 | 3, 360 |
| 1965–66 | 49 | 14, 020 | 3, 198 |
| 1964–65 | 49 | 13, 876 | 3, 181 |
| 1963–64 | 48 | 13, 691 | 3, 213 |
| 1962–63 | 48 | 13, 576 | 3, 233 |
| 1961–62 | 47 | 13, 513 | 3, 207 |
| 1960–61 | 47 | 13, 580 | 3, 290 |
| 1959–60 | 47 | 13, 581 | 3, 251 |
| 1954–55 | 43 | 12, 601 | 3, 085 |
| 1949–50 | 41 | 11, 460 | 2, 563 |

Source: Council on Dental Education: "Dental Students' Register," Chicago. American Dental Association. Annual issues through 1966–67. Also, "Annual Report on Dental Education," for later years.

TABLE 93.—*Undergraduate enrollment in the dental schools of the United States, as of Oct. 15, 1975*

| State and dental school | 1st year | | 2d year | | 3d year | | 4th year | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Men | Women | Men | Women | Men | Women | Men | Women | Men | Women | Combined |
| Alabama: University of Alabama | 62 | 10 | 64 | 6 | 51 | 3 | 68 | 2 | 245 | 21 | 266 |
| California: | | | | | | | | | | | |
| University of the Pacific [1] | 125 | 13 | 121 | 14 | | | 123 | 8 | 369 | 35 | 404 |
| University of California | 78 | 10 | 79 | 7 | 75 | 11 | 86 | 6 | 318 | 34 | 352 |
| University of California | 83 | 23 | 79 | 27 | 74 | 33 | 86 | 16 | 322 | 99 | 421 |
| University of California at Los Angeles | | | | | | | | | | | |
| University of Southern California | 123 | 16 | 122 | 18 | 110 | 2 | 123 | 5 | 478 | 41 | 519 |
| Loma Linda University | 67 | 6 | 70 | 5 | 69 | 5 | 64 | 5 | 270 | 21 | 291 |
| Colorado: University of Colorado | 23 | 2 | 21 | 3 | 23 | 1 | | | 67 | 6 | 73 |
| Connecticut: University of Connecticut | 44 | 8 | 36 | 8 | 27 | 6 | 26 | 4 | 133 | 26 | 159 |
| District of Columbia: | | | | | | | | | | | |
| Georgetown University | 139 | 11 | 140 | 9 | 137 | 7 | 134 | 2 | 550 | 29 | 579 |
| Howard University | 84 | 21 | 88 | 18 | 75 | 16 | 77 | 17 | 324 | 72 | 396 |
| Florida: University of Florida | 53 | 7 | 38 | 2 | 21 | 2 | 22 | 2 | 134 | 13 | 147 |
| Georgia: | | | | | | | | | | | |
| Emory University | 98 | 6 | 93 | 7 | 96 | 4 | 106 | 1 | 393 | 18 | 411 |
| Medical College of Georgia [1] | 54 | 11 | 51 | 6 | | | 54 | 4 | 159 | 21 | 180 |
| Illinois: | | | | | | | | | | | |
| Loyola University | 124 | 15 | 113 | 20 | 133 | 3 | 125 | 3 | 495 | 41 | 536 |
| Northwestern University | 95 | 10 | 95 | 8 | 98 | 1 | 97 | 2 | 385 | 21 | 406 |
| Southern Illinois University [1] | 37 | 6 | 36 | 9 | | | 35 | 1 | 108 | 16 | 124 |
| University of Illinois | 132 | 16 | 111 | 16 | 123 | 8 | 120 | 4 | 486 | 44 | 530 |
| Indiana: Indiana University | 118 | 12 | 120 | 13 | 116 | 4 | 117 | 8 | 471 | 37 | 508 |
| Iowa: University of Iowa | 82 | 14 | 78 | 17 | 86 | 4 | 76 | 2 | 322 | 37 | 359 |
| Kentucky: | | | | | | | | | | | |
| University of Kentucky | 50 | 10 | 57 | 5 | 60 | 6 | 53 | 6 | 220 | 27 | 247 |
| University of Louisville | 76 | 13 | 77 | 5 | 69 | 8 | 83 | 3 | 305 | 29 | 334 |
| Louisiana: Louisiana State University | 87 | 10 | 86 | 6 | 95 | 2 | 84 | 4 | 352 | 22 | 374 |
| Maryland: University of Maryland | 119 | 19 | 120 | 16 | 114 | 7 | 119 | 7 | 472 | 49 | 521 |
| Massachusetts: | | | | | | | | | | | |
| Harvard School of Dental Medicine | 14 | 6 | 10 | 8 | 14 | 8 | 14 | 5 | 52 | 27 | 79 |
| Boston University [2] | 29 | 9 | 31 | 6 | 25 | 3 | | | 85 | 18 | 103 |
| Tufts University [1] | 126 | 30 | 120 | 28 | | | 116 | 18 | 362 | 76 | 438 |
| Michigan: | | | | | | | | | | | |
| University of Detroit [1] | 92 | 7 | 90 | 7 | | | 87 | 3 | 269 | 17 | 286 |
| University of Michigan | 131 | 20 | 124 | 28 | 140 | 14 | 132 | 4 | 527 | 66 | 593 |
| Minnesota: University of Minnesota | 132 | 18 | 126 | 16 | 130 | 10 | 127 | 6 | 515 | 50 | 565 |
| Mississippi: University of Mississippi | 23 | 2 | | | | | | | 23 | 2 | 25 |
| Missouri: | | | | | | | | | | | |
| University of Missouri at Kansas City | 145 | 15 | 153 | 9 | 156 | 2 | 151 | 1 | 605 | 27 | 632 |
| Washington University | 77 | 10 | 77 | 3 | 59 | 4 | 58 | 1 | 271 | 14 | 289 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Nebraska: | | | | | | | | | | | |
| Creighton University | 70 | 5 | 67 | 5 | 69 | 3 | 67 | 1 | 273 | 16 | 287 |
| University of Nebraska | 63 | 3 | 58 | 4 | 65 | 1 | 63 | | 249 | 8 | 257 |
| New Jersey: | | | | | | | | | | | |
| Fairleigh Dickinson | 75 | 8 | 76 | 7 | 74 | 7 | 76 | 2 | 301 | 24 | 325 |
| New Jersey Dental School [1] | 55 | 9 | 57 | 9 | | | 59 | 6 | 171 | 24 | 195 |
| New York: Columbia University | 41 | 11 | 40 | 12 | 45 | 10 | 44 | 3 | 170 | 36 | 206 |
| New York University | 168 | 24 | 177 | 6 | 187 | 10 | 11 | 1 | 543 | 41 | 584 |
| State University of New York at Stony Brook | 19 | 5 | 15 | 8 | 18 | 4 | | | 52 | 17 | 69 |
| State University of New York at Buffalo | 85 | 5 | 81 | 6 | 85 | 4 | 85 | 2 | 336 | 17 | 353 |
| North Carolina: University of North Carolina | 72 | 11 | 69 | 14 | 74 | 5 | 82 | 2 | 297 | 32 | 329 |
| Ohio: | | | | | | | | | | | |
| Ohio State University | 178 | 22 | 182 | 11 | 187 | 4 | 161 | 3 | 708 | 40 | 748 |
| Case Western Reserve University | 81 | 21 | 84 | 15 | 92 | 7 | 91 | 5 | 348 | 48 | 396 |
| Oklahoma: University of Oklahoma | 31 | 5 | 22 | 1 | 23 | 1 | 24 | | 100 | 7 | 107 |
| Oregon: University of Oregon | 73 | 10 | 68 | 8 | 74 | 3 | 78 | 2 | 293 | 23 | 316 |
| Pennsylvania: | | | | | | | | | | | |
| Temple University | 140 | 9 | 130 | 10 | 133 | 6 | 144 | 1 | 547 | 26 | 573 |
| University of Pennsylvania | 133 | 28 | 133 | 25 | 147 | 15 | 146 | 7 | 559 | 75 | 634 |
| University of Pittsburgh | 114 | 20 | 113 | 17 | 122 | 10 | 125 | 7 | 474 | 54 | 528 |
| South Carolina: Medical University of South Carolina [1] | 50 | 5 | 49 | 3 | | | 56 | 2 | 155 | 10 | 165 |
| Tennessee: | | | | | | | | | | | |
| Meharry Medical College | 31 | 16 | 33 | 5 | 35 | 7 | 30 | 1 | 129 | 29 | 158 |
| University of Tennessee | 74 | 4 | 149 | 5 | 82 | 2 | 144 | 7 | 449 | 18 | 467 |
| Texas: | | | | | | | | | | | |
| Baylor College of Dentistry [1] | 121 | 8 | 118 | 7 | | | 110 | 4 | 349 | 19 | 368 |
| University of Texas at Houston | 110 | 14 | 114 | 9 | 111 | 8 | 120 | 5 | 455 | 36 | 491 |
| University of Texas at San Antonio | 138 | 14 | 28 | 4 | 28 | 4 | 29 | | 223 | 22 | 245 |
| Virginia: Virginia Commonwealth University | 97 | 13 | 99 | 12 | 100 | 7 | 113 | 1 | 409 | 33 | 442 |
| Washington: University of Washington | 81 | 19 | 74 | 18 | 92 | 4 | 88 | 2 | 335 | 43 | 378 |
| West Virginia: West Virginia University | 57 | 6 | 59 | 3 | 58 | 2 | 55 | 1 | 229 | 12 | 241 |
| Wisconsin: Marquette University | 127 | 10 | 124 | 11 | 126 | 11 | 125 | 6 | 502 | 38 | 540 |
| Puerto Rico: University of Puerto Rico | 50 | 16 | 32 | 18 | 39 | 10 | 42 | 11 | 163 | 55 | 218 |
| Total United States | 5,056 | 707 | 4,877 | 603 | 4,242 | 319 | 4,731 | 232 | 18,906 | 1,861 | 20,767 |
| Total per year | 5,763 | | 5,480 | | 4,561 | | 4,963 | | | | |

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[1] This is a 4–3 program; the enrollment figures given include the junior year.
[2] Due to transition in 1974 from a 4–3 to a 4–4 program, there are no seniors this year.

Source: "Dental Education Annual Report, 1975–76." ADA, 1975.

TABLE 94.—*U.S. dental schools—women enrollment by class, 1974–75 and 1975–76*

| | 1st year | 2d year | 3d year | 4th year | Total |
|---|---|---|---|---|---|
| 1974–75 | 631 | 388. 0 | 202. 0 | 140. 0 | 1, 361. 0 |
| 1975–76 | 707 | 603. 0 | 319. 0 | 232. 0 | 1, 861. 0 |
| Increase (percent) | 12 | 55. 4 | 57. 9 | 65. 7 | 36. 7 |

Source: "Dental Education Annual Report, 1975–76." ADA 1975.

TABLE 95.—*U.S. dental schools—minority enrollment and graduates, 1975–76*

| | Black | Puerto Rican | Mexican American | American Indian | Oriental | Other |
|---|---|---|---|---|---|---|
| 1st year | 298 | 11 | 64 | 22 | 186 | 56 |
| 2d year | 258 | 7 | 67 | 12 | 145 | 47 |
| 3d year | 207 | 5 | 57 | 11 | 115 | 20 |
| 4th year | 214 | 1 | 51 | 3 | 142 | 21 |
| Total | 977 | 24 | 239 | 48 | 588 | 144 |
| 1975 graduates | 187 | 6 | 33 | 5 | 107 | 30 |

Source: "Dental Education Annual Report, 1975–76." ADA, 1975.

TABLE 96.—*Dental school graduates, 1975*

| State and dental school | Men | Women | Total number of graduates |
|---|---|---|---|
| Alabama: University of Alabama | 66 | ---------- | 66 |
| California: | | | |
| University of the Pacific | 116 | 3 | 119 |
| University of California | 71 | 3 | 74 |
| University of California at Los Angeles | 94 | 7 | 101 |
| University of Southern California | 115 | 7 | 122 |
| Loma Linda University | 50 | 5 | 55 |
| Colorado: University of Colorado | | | |
| Connecticut: University of Connecticut [1] | 14 | 2 | 16 |
| District of Columbia: | | | |
| Georgetown University | 113 | 3 | 116 |
| Howard University | 77 | 8 | 85 |
| Florida: University of Florida | | | |
| Georgia: | | | |
| Emory University | 84 | 2 | 86 |
| Medical College of Georgia | 58 | 2 | 60 |
| Illinois: | | | |
| Loyola University | 120 | 1 | 121 |
| Northwestern University | 82 | 2 | 84 |
| Southern Illinois University | 20 | ---------- | 20 |
| University of Illinois | 102 | 2 | 104 |
| Indiana: Indiana University | 106 | 7 | 113 |
| Iowa: University of Iowa | 70 | 1 | 71 |
| Kentucky: | | | |
| University of Kentucky | 54 | 2 | 56 |
| University of Louisville | 70 | 4 | 74 |
| Louisiana: Louisiana State University | 71 | 4 | 75 |
| Maryland: University of Maryland | 117 | 3 | 120 |
| Massachusetts: | | | |
| Harvard School of Dental Medicine | 14 | 2 | 16 |
| Boston University | | | |
| Tufts University | 223 | 3 | 226 |

Footnote at end of table.

TABLE 96.—*Dental school graduates, 1975*—Continued

| State and dental school | Men | Women | Total number of graduates |
|---|---|---|---|
| Michigan: | | | |
| University of Detroit | 86 | 2 | 88 |
| University of Michigan | 134 | 6 | 140 |
| Minnesota: University of Minnesota | 116 | 2 | 118 |
| Mississippi: University of Mississippi | — | — | — |
| Missouri: University of Missouri at Kansas City | 130 | 3 | 133 |
| Nebraska: | | | |
| Creighton University | 51 | — | 51 |
| University of Nebraska | 57 | 1 | 58 |
| New Jersey: | | | |
| Farleigh Dickinson University | 68 | 5 | 73 |
| New Jersey Dental School | 57 | 4 | 61 |
| New York: | | | |
| Columbia University | 40 | 3 | 43 |
| New York University | 313 | 11 | 324 |
| State University of New York at Stony Brook | — | — | — |
| State University of New York at Buffalo | 80 | 4 | 84 |
| North Carolina: University of North Carolina | 72 | 1 | 73 |
| Ohio: | | | |
| Ohio State University | 151 | 1 | 152 |
| Case Western Reserve University | 76 | 4 | 80 |
| Oklahoma: University of Oklahoma | — | — | — |
| Oregon: University of Oregon | 75 | 2 | 77 |
| Pennsylvania: | | | |
| Temple University | 118 | 2 | 120 |
| University of Pennsylvania | 149 | 7 | 156 |
| University of Pittsburgh | 112 | 3 | 115 |
| South Carolina: Medical University of South Carolina | 76 | 2 | 78 |
| Tennessee: | | | |
| Meharry Medical College | 33 | 6 | 39 |
| University of Tennessee | 140 | 1 | 141 |
| Texas: | | | |
| Baylor College of Dentistry | 214 | 1 | 215 |
| University of Texas at Houston | 103 | 2 | 105 |
| University of Texas at San Antonio | 14 | 2 | 16 |
| Virginia: Virginia Commonwealth University | 93 | 1 | 94 |
| Washington: University of Washington | 85 | — | 85 |
| West Virginia: West Virginia University | 60 | 2 | 62 |
| Wisconsin: Marquette University | 117 | 1 | 118 |
| Puerto Rico: University of Puerto Rico | 33 | 3 | 36 |
| Total, United States | 4, 813 | 156 | 4, 969 |
| Percent with degree | 96 | 3 | — |

[1] Information on baccalaureate degrees obtained after admission not available.

Source: "Dental Education Annual Report, 1975–76." ADA, 1975.

## IV. Optometric Manpower

TABLE 97.—*Optometrists in relation to population: selected years 1950 through 1973*

| Year | Population in thousands [1] | Optometrists [2] | Optometrists per 100,000 population |
|---|---|---|---|
| 1973 | 210, 557 | 21, 798 | 10 |
| 1971 | 207, 336 | 20, 736 | 10 |
| 1969 | 203, 145 | 20, 611 | 10 |
| 1968 | 201, 005 | 20, 301 | 10 |
| 1967 | 199, 017 | 20, 565 | 10 |
| 1966 | 196, 967 | 20, 610 | 11 |
| 1964 | 191, 372 | 20, 818 | 11 |
| 1960 | 179, 992 | 21, 824 | 12 |
| 1950 | 151, 234 | 20, 792 | 14 |

[1] Includes civilians and members of armed forces in 50 States and the District of Columbia for 1960–67. Excludes Hawaii and Alaska for 1950. As of December for 1967–73. As of March for 1966. As of July 1 for 1950–64.

[2] Active and inactive optometrists.

Sources: The Blue Book of Optometrists. Chicago. Professional Press, Inc., 1972. Also, prior biennial editions of this directory. National Center for Health Statistics, Division of Health Manpower and Facilities Statistics—data collected in the 1968 vision and eye care manpower survey of optometrists, September to December 1968. Data collected from Optometric resources project conducted under contract with the Bureau of Health Manpower, 1973. U.S. Bureau of the Census: Population estimates. Current Population Reports, Series P–25, Nos. 229, 422, 442, 478 and 533.

TABLE 98.—*Location of optometrists: December 1973*

| Location | Total [1] | Active [1] |
|---|---|---|
| All locations | 21, 798 | 19, 356 |
| United States | 21, 701 | 19, 268 |
| Alabama | 193 | 181 |
| Alaska | 18 | 18 |
| Arizona | 179 | 148 |
| Arkansas | 178 | 163 |
| California | 2, 820 | 2, 421 |
| Colorado | 220 | 208 |
| Connecticut | 303 | 267 |
| Delaware | 47 | 39 |
| District of Columbia | 75 | 68 |
| Florida | 799 | 621 |
| Georgia | 306 | 290 |
| Hawaii | 88 | 74 |
| Idaho | 90 | 86 |
| Illinois | 1, 825 | 1, 569 |
| Indiana | 592 | 538 |
| Iowa | 335 | 314 |
| Kansas | 262 | 247 |
| Kentucky | 243 | 225 |
| Louisiana | 243 | 225 |
| Maine | 138 | 123 |
| Maryland | 245 | 210 |
| Massachusetts | 849 | 749 |
| Michigan | 825 | 745 |
| Minnesota | 391 | 361 |
| Mississippi | 137 | 124 |
| Missouri | 480 | 422 |
| Montana | 108 | 101 |
| Nebraska | 164 | 149 |
| Nevada | 57 | 48 |
| New Hampshire | 82 | 72 |
| New Jersey | 753 | 675 |
| New Mexico | 86 | 80 |
| New York | 1, 836 | 1, 590 |
| North Carolina | 358 | 337 |
| North Dakota | 80 | 74 |
| Ohio | 1, 060 | 974 |
| Oklahoma | 293 | 273 |
| Oregon | 338 | 305 |
| Pennsylvania | 1, 285 | 1, 128 |
| Rhode Island | 140 | 127 |
| South Carolina | 195 | 179 |
| South Dakota | 95 | 87 |
| Tennessee | 400 | 363 |
| Texas | 911 | 828 |
| Utah | 87 | 75 |
| Vermont | 47 | 44 |
| Virginia | 350 | 325 |
| Washington | 435 | 385 |
| West Virginia | 149 | 136 |
| Wisconsin | 473 | 436 |
| Wyoming | 40 | 40 |
| Canal Zone | 3 | 2 |
| Guam | 3 | 3 |
| Puerto Rico | 7 | 6 |
| Virgin Islands | 2 | 2 |
| Foreign | 65 | 60 |
| Not reported | 17 | 15 |

[1] Figures may not add to totals due to rounding.

Source: Data collected from optometric manpower resources project conducted under contract with the Bureau of Health Manpower.

TABLE 99.—*Principal form of employment of optometrists: 1973*

| Type of practice | Optometrists | |
|---|---|---|
| | Number | Percent |
| All active optometrists | [1] 19, 356 | 100. 0 |
| Total self-employed | 14, 913 | 77. 0 |
| Solo practice | 11, 905 | 61. 5 |
| Partnership practice | 2, 518 | 13. 0 |
| Group practice | 490 | 2. 5 |
| Total employees | 3, 636 | 18. 8 |
| Employed by: | | |
| Government | 538 | 2. 8 |
| Optometrist(s) | 1, 066 | 5. 5 |
| Ophthalmologist(s) | 158 | . 8 |
| Physician(s) other than ophthalmologist(s) | 17 | . 1 |
| Firm or corporation (proprietary) | 1, 229 | 6. 3 |
| Nonprofit organization or institution | 371 | 1. 9 |
| Other forms of employment | 256 | 1. 3 |
| Not reported | 807 | 4. 2 |

[1] Subtotals may not add to totals due to rounding.

Source: Data collected from optometric manpower resources project conducted under contract with the Bureau of Health Manpower.

TABLE 100.—*Schools of optometry, students and graduates: selected years, 1964–65 through 1973–74*

| Academic year | Schools | Students [1] | | Graduates |
|---|---|---|---|---|
| | | Total | 1st year | |
| 1973–74 | 12 | 3, 529 | 988 | 684 |
| 1972–73 | 12 | 3, 328 | 984 | 691 |
| 1971–72 | 12 | 3, 094 | 906 | 683 |
| 1970–71 | 11 | 2, 831 | 884 | 528 |
| 1969–70 | 11 | 2, 488 | 786 | 445 |
| 1968–69 | 10 | 2, 203 | 771 | 441 |
| 1967–68 | 10 | 1, 962 | 646 | 477 |
| 1966–67 | 10 | 1, 882 | 669 | 481 |
| 1965–66 | 10 | 1, 745 | 643 | 413 |
| 1964–65 | 10 | 1, 547 | 593 | 377 |

[1] Fall enrollment of undergraduate students.

Source: American Optometric Association.

## V. Pharmacist Manpower

TABLE 101.—*Pharmacist registrations according to residence and activity status and ratio of pharmacists to population: Jan. 1, 1973*

| Location | Total registrations | Pharmacists resident in State | | | Pharmacists out of State | Resident pharmacists in practice per 100,000 population [1] |
|---|---|---|---|---|---|---|
| | | Total | In practice | Not in practice | | |
| Total | 191,247 | 145,374 | 132,899 | 12,475 | 45,876 | 62.0 |
| Alabama | [2] 2,674 | 2,477 | 2,301 | 176 | 197 | 66.7 |
| Alaska | 188 | 121 | 96 | 25 | 67 | 29.5 |
| Arizona | 2,881 | 1,393 | 1,171 | 222 | 1,488 | 60.2 |
| Arkansas | 1,821 | 1,311 | 1,098 | 213 | 510 | 55.5 |
| California | 14,626 | 13,639 | 12,485 | 1,154 | 987 | 61.0 |
| Colorado | 3,412 | 1,953 | 1,631 | 322 | 1,459 | 69.2 |
| Connecticut | [2] 2,507 | 2,235 | 2,105 | 130 | 272 | 68.3 |
| Delaware | 537 | 282 | 259 | 23 | 255 | 45.8 |
| District of Columbia | 1,555 | 625 | 570 | 55 | 930 | 76.2 |
| Florida | 6,310 | 4,750 | 4,370 | 380 | 1,560 | 60.2 |
| Georgia | 4,572 | 3,730 | 3,280 | 450 | 842 | 69.5 |
| Hawaii | 343 | 268 | 268 | ---------- | 75 | 33.1 |
| Idaho | 1,429 | 583 | 510 | 73 | 846 | 67.5 |
| Illinois | [2] 9,720 | 6,634 | 6,163 | 471 | 3,086 | 54.8 |
| Indiana | 5,573 | 3,732 | 3,276 | 456 | 1,841 | 61.9 |
| Iowa | 3,076 | 1,821 | 1,635 | 186 | 1,255 | 56.7 |
| Kansas | 2,347 | 1,739 | 1,482 | 257 | 608 | 65.6 |
| Kentucky | 2,527 | 2,047 | 1,789 | 258 | 480 | 54.2 |
| Louisiana | 3,186 | 2,471 | 2,411 | 60 | 715 | 64.8 |
| Maine | 789 | 526 | 520 | 6 | 263 | 50.5 |
| Maryland | 3,210 | 2,585 | 2,372 | 213 | 625 | 58.5 |
| Massachusetts | 7,083 | 5,511 | 5,021 | 490 | 1,572 | 36.6 |
| Michigan | 6,549 | 5,965 | 5,585 | 380 | 584 | 61.5 |
| Minnesota | 3,413 | 2,553 | 2,367 | 186 | 860 | 60.8 |
| Mississippi | 1,609 | 1,249 | 1,186 | 63 | 360 | 52.4 |
| Missouri | 4,610 | 3,288 | 2,682 | 606 | 1,322 | 56.4 |
| Montana | [2] 846 | 531 | 447 | 84 | 315 | 62.2 |
| Nebraska | 2,196 | 1,259 | 1,012 | 247 | 937 | 66.4 |
| Nevada | 3,311 | 345 | 330 | 15 | 2,966 | 62.6 |
| New Hampshire | 674 | 415 | 355 | 60 | 259 | 46.0 |
| New Jersey | 5,890 | 4,763 | 4,024 | 739 | 1,127 | 54.6 |
| New Mexico | 1,181 | 640 | 607 | 33 | 541 | 57.0 |
| New York | 18,325 | 14,420 | 14,076 | 344 | 3,905 | 76.6 |
| North Carolina | 2,967 | 2,464 | 2,204 | 260 | 503 | 42.3 |
| North Dakota | 1,355 | 489 | 447 | 42 | 866 | 70.7 |
| Ohio | 8,524 | 7,648 | [3] 7,274 | 374 | 876 | 67.5 |
| Oklahoma | 3,131 | 2,253 | 2,173 | 80 | 878 | 82.5 |
| Oregon | 2,267 | 1,540 | 1,368 | 172 | 727 | 62.7 |
| Pennsylvania | [2] 12,081 | 11,404 | 10,559 | 845 | 677 | 88.5 |
| Puerto Rico | 1,133 | 1,133 | 1,066 | 67 | ---------- | [4] 39.6 |
| Rhode Island | 1,257 | 710 | 549 | 161 | 547 | 56.7 |
| South Carolina | 1,932 | 1,545 | 1,509 | 36 | 387 | 56.6 |
| South Dakota | 901 | 480 | 463 | 17 | 421 | 68.2 |
| Tennessee | 3,541 | 2,609 | 2,477 | 132 | 932 | 61.4 |
| Texas | 8,759 | 7,144 | 6,418 | 726 | 1,615 | 55.1 |
| Utah | 1,366 | 812 | 769 | 43 | 554 | 68.3 |
| Vermont | 869 | 232 | 225 | 7 | 637 | 48.7 |
| Virginia | [2] 2,968 | 2,335 | 2,065 | 270 | 633 | 43.3 |
| Virgin Islands | ---------- | ---------- | ---------- | ---------- | ---------- | ---------- |
| Washington | 3,738 | 2,838 | 2,507 | 331 | 900 | 72.8 |
| West Virginia | 1,227 | 793 | 743 | 50 | 434 | 41.7 |
| Wisconsin | 3,477 | 2,789 | 2,394 | 395 | 688 | 53.0 |
| Wyoming | 784 | 295 | 205 | 90 | 489 | 59.4 |

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[1] Total Civilian Resident Population, "Current Population Reports," U.S. Bureau of Census, series P–25, No. 500.

[2] As of Jan. 1, 1972.

[3] Estimated.

[4] Total Civilian Resident Population, estimated by U.S. Bureau of Census for Puerto Rico, July 1, 1972, series P–25.

Source: "Licensure Statistics, Census." National Associations of Boards of Pharmacy, 1974.

TABLE 102.—*Type of practice of pharmacists by States: Jan. 1, 1973*

| Location | Total licensed in State | In practice | | | | | | | Not in practice |
|---|---|---|---|---|---|---|---|---|---|
| | | | Community pharmacy | | | | | | |
| | | Total in practice in State | Total in community practice in State | Owner | Employee | Hospital pharmacy | Manufacturing | Teaching, government, and other pharmaceutical capacities | |
| Total | 145, 374 | 132, 899 | 109, 113 | 46, 118 | 62, 995 | 13, 310 | 5, 237 | 5, 239 | 12, 475 |
| Alabama | [1] 2, 477 | 2, 301 | 1, 933 | 810 | 1, 123 | 230 | 23 | 115 | 176 |
| Alaska | 121 | 96 | 80 | 13 | 67 | 8 | 8 | ---------- | 25 |
| Arizona | 1, 393 | 1, 171 | 867 | 223 | 644 | 217 | 52 | 55 | 222 |
| Arkansas | 1, 311 | 1, 098 | 965 | 459 | 506 | 104 | 13 | 16 | 213 |
| California | 13, 639 | 12, 485 | 10, 860 | 5, 539 | 5, 321 | 1, 065 | 360 | 200 | 1, 154 |
| Colorado | 1, 953 | 1, 631 | 1, 312 | 376 | 936 | 198 | 46 | 75 | 322 |
| Connecticut | [1] 2, 235 | 2, 105 | 1, 595 | 707 | 888 | 265 | 208 | 42 | 130 |
| Delaware | 282 | 259 | 209 | 69 | 140 | 30 | 7 | 13 | 23 |
| District of Columbia | 625 | 570 | 463 | 74 | 389 | 57 | 20 | 30 | 55 |
| Florida | 4, 750 | 4, 370 | 3, 728 | 1, 454 | 2, 274 | 358 | 35 | 249 | 380 |
| Georgia | 3, 730 | 3, 280 | 2, 477 | 1, 344 | 1, 133 | 195 | 336 | 272 | 450 |
| Hawaii | 268 | 268 | 190 | 60 | 130 | 49 | 21 | 8 | 0 |
| Idaho | 583 | 510 | 444 | 173 | 271 | 28 | 23 | 15 | 73 |
| Illinois | [1] 6, 634 | 6, 163 | 5, 046 | 1, 980 | 3, 066 | 889 | 193 | 35 | 471 |
| Indiana | 3, 732 | 3, 276 | 2, 620 | 886 | 1, 734 | 338 | 231 | 87 | 456 |
| Iowa | 1, 821 | 1, 635 | 1, 181 | 579 | 602 | 164 | 77 | 213 | 186 |
| Kansas | 1, 739 | 1, 482 | 1, 309 | 715 | 594 | 119 | 30 | 24 | 257 |
| Kentucky | 2, 047 | 1, 789 | 1, 452 | 623 | 829 | 189 | 55 | 93 | 258 |
| Louisiana | 2, 471 | 2, 411 | 2, 189 | 950 | 1, 239 | 110 | 52 | 60 | 60 |
| Maine | 526 | 520 | 494 | 150 | 344 | 15 | 4 | 7 | 6 |
| Maryland | 2, 585 | 2, 372 | 1, 866 | 403 | 1, 463 | 236 | 97 | 173 | 213 |

TABLE 102.—*Type of practice of pharmacists by States: Jan. 1, 1973* —Continued

| Location | Total licensed in State | In practice | | | | | | | Not in practice |
|---|---|---|---|---|---|---|---|---|---|
| | | Total in practice in State | Community pharmacy | | | Hospital pharmacy | Manufacturing | Teaching, government, and other pharmaceutical capacities | |
| | | | Total in community practice in State | Owner | Employee | | | | |
| Massachusetts | 5, 511 | 5, 021 | 4, 057 | 1, 664 | 2, 393 | 411 | 267 | 286 | 490 |
| Michigan | 5, 965 | 5, 585 | 4, 787 | 1, 996 | 2, 791 | 608 | 151 | 39 | 380 |
| Minnesota | 2, 553 | 2, 367 | 1, 704 | 771 | 933 | 254 | 41 | 368 | 186 |
| Mississippi | 1, 249 | 1, 186 | 892 | 477 | 415 | 231 | 25 | 38 | 63 |
| Missouri | 3, 288 | 2, 682 | 2, 212 | 943 | 1, 269 | 326 | 144 | ---------- | 606 |
| Montana | [1] 531 | 447 | 374 | 215 | 159 | 51 | 9 | 13 | 84 |
| Nebraska | 1, 259 | 1, 012 | 826 | 381 | 445 | 97 | 65 | 24 | 247 |
| Nevada | 345 | 330 | 292 | 88 | 204 | 25 | 5 | 8 | 15 |
| New Hampshire | 415 | 355 | 303 | 135 | 168 | 43 | 6 | 3 | 60 |
| New Jersey | 4, 763 | 4, 024 | 3, 585 | 1, 792 | 1, 793 | 163 | 227 | 49 | 739 |
| New Mexico | 640 | 607 | 517 | 217 | 300 | 64 | 12 | 14 | 33 |
| New York | 14, 420 | 14, 076 | 10, 670 | 2, 732 | 7, 938 | 1, 647 | 731 | 1, 028 | 344 |
| North Carolina | 2, 464 | 2, 204 | 1, 889 | 820 | 1, 069 | 241 | 39 | 35 | 260 |
| North Dakota | 489 | 447 | 336 | 198 | 138 | 76 | 20 | 15 | 42 |
| Ohio | 7, 648 | [2] 7, 274 | 5, 906 | 2, 534 | 3, 372 | 975 | 255 | 138 | 374 |
| Oklahoma | 2, 253 | 2, 173 | 1, 859 | 676 | 1, 183 | 99 | 121 | 94 | 80 |
| Oregon | 1, 540 | 1, 368 | 1, 154 | 428 | 726 | 149 | 19 | 46 | 172 |
| Pennsylvania | [1] 11, 404 | 10, 559 | 8, 848 | 4, 919 | 3, 929 | 739 | 697 | 275 | 845 |
| Puerto Rico | 1, 133 | 1, 066 | 967 | 317 | 650 | 17 | 30 | 52 | 67 |
| Rhode Island | 710 | 549 | 428 | 97 | 331 | 87 | 15 | 19 | 161 |
| South Carolina | 1, 545 | 1, 509 | 1, 397 | 562 | 835 | 68 | 12 | 32 | 36 |
| South Dakota | 480 | 463 | 410 | 129 | 281 | 23 | 19 | 11 | 17 |
| Tennessee | 2, 609 | 2, 477 | 2, 072 | 919 | 1, 153 | 243 | 82 | 80 | 132 |
| Texas | 7, 144 | 6, 418 | 5, 268 | 2, 312 | 2, 956 | 697 | 172 | 281 | 726 |
| Utah | 812 | 769 | 625 | 244 | 381 | 68 | 33 | 43 | 43 |
| Vermont | 232 | 225 | 211 | 101 | 110 | 14 | ---------- | ---------- | 7 |
| Virginia | [1] 2, 335 | 2, 065 | 1, 540 | 612 | 928 | 179 | 37 | 309 | 270 |
| Virgin Islands | ---------- | ---------- | ---------- | ---------- | ---------- | ---------- | ---------- | ---------- | ---------- |
| Washington | 2, 838 | 2, 507 | 1, 985 | 1, 191 | 794 | 351 | 70 | 101 | 331 |
| West Virginia | 793 | 743 | 659 | 254 | 405 | 65 | 7 | 12 | 50 |
| Wisconsin | 2, 789 | 2, 394 | 1, 882 | 720 | 1, 162 | 423 | 53 | 36 | 395 |
| Wyoming | 295 | 205 | 178 | 87 | 91 | 17 | 2 | 8 | 90 |

[1] As of Jan. 1, 1972.
[2] Estimated.

Source: "Licensure Statistics, Census." National Association of Boards of Pharmacy, 1974.

Table 103.—*Schools of pharmacy, students, and graduates 1960–61 through 1973–74*

| Academic year | Schools | Students [1] | Graduates |
|---|---|---|---|
| 1973–74 | 74 | 21, 307 | ------------- |
| 1972–73 | 74 | 19, 040 | 5, 725 |
| 1971–72 | 75 | 16, 894 | 5, 313 |
| 1970–71 | 75 | 15, 734 | 5, 232 |
| 1969–70 | 75 | 15, 392 | 4, 771 |
| 1968–69 | 75 | 14, 986 | 4, 734 |
| 1967–68 | 75 | 14, 324 | 4, 301 |
| 1966–67 | 75 | 13, 261 | 4, 039 |
| 1965–66 | 75 | 12, 518 | 3, 799 |
| 1964–65 | 76 | 12, 088 | 3, 692 |
| 1963–64 | 77 | 10, 405 | 3, 388 |
| 1962–63 | 77 | 10, 761 | 2, 218 |
| 1961–62 | 77 | 10, 974 | 4, 214 |
| 1960–61 | 77 | 13, 755 | 3, 749 |

[1] Includes enrollment in last 3 yr of pharmacy school program leading to B.S., B. Pharm., and Pharm. D. degrees.

Source: American Association of Colleges of Pharmacy: "American Journal of Pharmaceutical Education 38": February 1974. Also, prior annual issues. Unpublished data on Hampden College, Mass.

## VI. Podiatric Manpower

TABLE 104.—*Location of total and active podiatrists in relation to population: 1974*

| Location | Number of podiatrists [1] |  | Active podiatrists per 100,000 resident population |
|---|---|---|---|
|  | Total | Active [2] |  |
| United States | 8, 261 | 7, 121 | 3. 4 |
| Alabama | 27 | 19 | . 5 |
| Alaska | 3 | 3 | . 9 |
| Arizona | 78 | 55 | 2. 6 |
| Arkansas | 22 | 20 | 1. 0 |
| California | 929 | 764 | 3. 7 |
| Colorado | 81 | 64 | 2. 6 |
| Connecticut | 201 | 173 | 5. 6 |
| Delaware | 20 | 18 | 3. 1 |
| District of Columbia | 54 | 51 | 6. 8 |
| Florida | 364 | 248 | 3. 2 |
| Georgia | 81 | 70 | 1. 4 |
| Hawaii | 8 | 8 | 1. 0 |
| Idaho | 18 | 15 | 1. 9 |
| Illinois | 682 | 570 | 5. 1 |
| Indiana | 148 | 128 | 2. 4 |
| Iowa | 97 | 84 | 2. 9 |
| Kansas | 52 | 42 | 1. 9 |
| Kentucky | 67 | 52 | 1. 5 |
| Louisiana | 40 | 36 | 1. 0 |
| Maine | 21 | 18 | 1. 7 |
| Maryland | 142 | 131 | 3. 2 |
| Massachusetts | 441 | 347 | 6. 0 |
| Michigan | 321 | 296 | 3. 3 |
| Minnesota | 80 | 70 | 1. 8 |
| Mississippi | 11 | 9 | . 4 |
| Missouri | 96 | 82 | 1. 7 |
| Montana | 14 | 14 | 1. 9 |
| Nebraska | 41 | 37 | 2. 4 |
| Nevada | 17 | 15 | 2. 6 |
| New Hampshire | 30 | 23 | 2. 9 |
| New Jersey | 408 | 355 | 4. 8 |
| New Mexico | 31 | 27 | 2. 4 |
| New York | 1, 367 | 1, 226 | 6. 8 |
| North Carolina | 57 | 55 | 1. 0 |
| North Dakota | 5 | 5 | . 8 |
| Ohio | 563 | 515 | 4. 8 |
| Oklahoma | 53 | 51 | 1. 9 |
| Oregon | 43 | 37 | 1. 6 |
| Pennsylvania | 761 | 674 | 5. 7 |
| Rhode Island | 60 | 53 | 5. 7 |
| South Carolina | 18 | 17 | . 6 |
| South Dakota | 14 | 12 | 1. 8 |
| Tennessee | 45 | 40 | 1. 0 |
| Texas | 242 | 208 | 1. 7 |
| Utah | 34 | 32 | 2. 7 |
| Vermont | 8 | 7 | 1. 5 |
| Virginia | 87 | 73 | 1. 5 |
| Washington | 77 | 66 | 1. 9 |
| West Virginia | 45 | 39 | 2. 2 |
| Wisconsin | 148 | 126 | 2. 8 |
| Wyoming | 9 | 7 | 2. 0 |

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[1] State figures may not add to total due to rounding.

[2] Includes 36 active podiatrists not providing patient care who were not asked to report their principal form of employment.

Sources: Data from the survey of podiatrists conducted October through December 1974, by the National Center for Health Statistics with the cooperation of the American Podiatry Association. U.S. Bureau of the Census: Population estimates. "Current Population Reports." Series P–26. Nos. 94–138, October 1974–September 1975. U.S. Bureau of the Census: Population estimates. "Current Population Reports." series P–25, Nos. 596, 597, 599, 602, 604, and 609.

TABLE 105.—*Type of practice of active podiatrists: 1974*

| Type of practice | Number | Percent |
|---|---|---|
| Total | [1] 7, 085 | 100. 0 |
| Self-employed | 6, 836 | 96. 5 |
| Solo practice | 5, 719 | 80. 7 |
| Partnership practice | 950 | 13. 4 |
| Group practice | 167 | 2. 4 |
| Salaried | 237 | 3. 4 |
| Government organization | 120 | 1. 7 |
| Nongovernment organization | 117 | 1. 7 |
| Other | 12 | . 1 |

[1] Excludes 36 active podiatrists not providing patient care who were not asked to report their principal form of employment.

Source: Podiatry manpower survey conducted October through December 1974, by the National Center for Health Statistics, Division of Health Manpower and Facilities Statistics.

TABLE 106.—*Podiatry colleges, students, and graduates; selected years, 1960–61 through 1974–75*

| Academic year | Colleges | Students | | Graduates |
|---|---|---|---|---|
| | | Total | 1st year | |
| 1974–75 | 6 | 1, 837 | 561 | ------- |
| 1973–74 | 6 | 1, 631 | 551 | 305 |
| 1972–73 | 5 | 1, 401 | 473 | 269 |
| 1971–72 | 5 | 1, 267 | 399 | 286 |
| 1970–71 | 5 | 1, 148 | 351 | 242 |
| 1969–70 | 5 | 1, 097 | 293 | 251 |
| 1968–69 | 5 | 1, 061 | 331 | 204 |
| 1967–68 | 5 | 924 | 291 | 162 |
| 1966–67 | 5 | 838 | 283 | 165 |
| 1964–65 | 5 | 622 | 177 | 122 |
| 1962–63 | 4 | 496 | 151 | 114 |
| 1960–61 | 5 | 478 | 107 | 116 |

Source: American Association of Colleges of Podiatric Medicine.

TABLE 107.—*Location and ownership of podiatry colleges and number of students and graduates 1974–75*

| Location and school [1] | Students | | Graduates (1974) |
|---|---|---|---|
| | Total | 1st year | |
| Total 6 schools | 1, 837 | 561 | 305 |
| California: California College of Podiatric Medicine, San Francisco | 305 | 89 | 54 |
| Illinois: Illinois College of Podiatric Medicine, Chicago | 490 | 163 | 57 |
| New York: | | | |
| New York College of Podiatric Medicine, New York | 241 | 68 | 42 |
| State University of New York Health Sciences Center, Stony Brook | | (2) | ---------- |
| Ohio: Ohio College of Podiatric Medicine, Cleveland | 469 | 125 | 100 |
| Pennsylvania: Pennsylvania College of Podiatric Medicine, Philadelphia | 332 | 116 | 52 |

[1] All colleges are private institutions.
[2] 1st class planned for fall of 1975.

Source: American Association of Colleges of Podiatric Medicine.

## VII. Chiropractic Manpower

TABLE 108.—*Location of active chiropractors in relation to population: April 1974*

| Location | Active [1] | Active chiropractors per 100,000 population |
|---|---|---|
| United States | 17,559 | 8 |
| Alabama | 260 | 7 |
| Alaska | 18 | 5 |
| Arizona | 248 | 12 |
| Arkansas | 128 | 6 |
| California | [2] 2,094 | 10 |
| Colorado | 225 | 9 |
| Connecticut | 117 | 4 |
| Delaware | 18 | 3 |
| District of Columbia | 5 | 1 |
| Florida | 799 | 10 |
| Georgia | 250 | 5 |
| Hawaii | 25 | 3 |
| Idaho | 58 | 8 |
| Illinois | 650 | 6 |
| Indiana | 295 | 6 |
| Iowa | 595 | 20 |
| Kansas | 559 | 25 |
| Kentucky | 405 | 12 |
| Louisiana | [3] 150 | 4 |
| Maine | 35 | 3 |
| Maryland | 173 | 4 |
| Massachusetts | 236 | 4 |
| Michigan | 825 | 9 |
| Minnesota | 465 | 12 |
| Mississippi | 200 | 9 |
| Missouri | 1,001 | 21 |
| Montana | 95 | 13 |
| Nebraska | 73 | 5 |
| Nevada | 48 | 9 |
| New Hampshire | 175 | 22 |
| New Jersey | 590 | 8 |
| New Mexico | 115 | 10 |
| New York | 1,492 | 8 |
| North Carolina | 244 | 5 |
| North Dakota | 68 | 11 |
| Ohio | 550 | 5 |
| Oklahoma | 331 | 12 |
| Oregon | 191 | 9 |
| Pennsylvania | 986 | 8 |
| Rhode Island | [2] 38 | 4 |
| South Carolina | 197 | 7 |
| South Dakota | 110 | 16 |
| Tennessee | 132 | 3 |
| Texas | 1,134 | 10 |
| Utah | [2] 75 | 6 |
| Vermont | 40 | 9 |
| Virginia | [2] 75 | 2 |
| Washington | 400 | 12 |
| West Virginia | 42 | 2 |
| Wisconsin | 480 | 11 |
| Wyoming | 44 | 12 |

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[1] Active number of chiropractors is based on the assumption that the licensing boards supplied only the number of chiropractors who practice in the State and not the total number of active licenses which cannot be verified.

[2] Previous figure used in absence of sufficient information on which to base revision.

[3] Estimated.

Source: American Chiropractic Association.

TABLE 109.—*Chiropractic schools: selected years, 1960–61 through 1973–74*

| Academic year | Schools | Students | Graduates |
|---|---|---|---|
| 1973–74 | 10 | [1] 4, 684 | ------------ |
| 1972–73 | 10 | [1] 3, 768 | [1] 654 |
| 1971–72 | 10 | [1] 2, 857 | [1] 653 |
| 1970–71 | 11 | 2, 497 | [1] 589 |
| 1969–70 | 11 | [1] 2, 477 | 642 |
| 1968–69 | 11 | 2, 449 | [1] 588 |
| 1967–68 | 12 | 2, 576 | 589 |
| 1966–67 | 12 | ------------ | 687 |
| 1964–65 | 12 | 2, 940 | 627 |
| 1962–63 | 12 | ------------ | 597 |
| 1960–61 | 12 | ------------ | 665 |

[1] Estimated.

Sources: American Chiropractic Association and the International Chiropractors Association.

TABLE 110.—*Location and ownership of chiropractic schools and number of students and graduates: 1973*

| Location and schools [1] | Students (1973–74) | Graduates (1973) |
|---|---|---|
| Total 10 schools | 4, 684 | 654 |
| Schools accredited by the Council on Chiropractic Education of the American Chiropractic Association: | | |
| California: Los Angeles College of Chiropractic, Glendale | 296 | 36 |
| Illinois: National College of Chiropractic, Lombard | 559 | 76 |
| Minnesota: Northwestern College of Chiropractic, Minneapolis | 127 | 27 |
| Oregon: Western States College of Chiropractic, Portland [2] | 137 | 7 |
| Texas: Texas Chiropractic College, Pasadena | 147 | 12 |
| Schools accredited by the Chiropractic Education Commission of the International Chiropractors Association: | | |
| California: Cleveland Chiropractic College, Los Angeles | [3] 450 | [3] 48 |
| Iowa: Palmer College of Chiropractic, Davenport | 1, 972 | 344 |
| Missouri: | | |
| Cleveland Chiropractic College, Kansas City | 350 | 30 |
| Logan Chiropractic College, St. Louis | 390 | 56 |
| New York: Columbia Institute of Chiropractic, New York | 256 | 18 |

[1] All private schools.
[2] A correspondent member but not accredited.
[3] Estimated.

Sources: American Chiropractic Association and the International Chiropractors Association.

# Chapter 3. Private Health Insurance

## Income, Expense, and Coverage

### MEDICAL CARE OUTLAYS, FISCAL YEAR 1975

The total personal health care bill for all Americans was $103 billion. Of this total, $33.6 billion (32.6 percent) was paid by direct payments of private funds; $40.9 billion (39.7 percent) was paid by public programs (Federal, State, and local); $27.3 billion (26.5 percent) was paid by private health insurance; and $1.3 billion (1.3 percent) was paid by philanthropy and other sources.

### PRIVATE HEALTH INSURANCE COVERAGE OF INDIVIDUAL HEALTH EXPENDITURES

(*a*) In fiscal year 1975, the average medical bill for a person (per capita personal health care expenditures) amounted to $476.40, of which 26.5 percent was paid by private health insurance. The person himself paid 32.6 percent, largely for uninsured items such as drugs, long-term institutional care, and dental care. The rest was paid primarily by Government programs (39.7 percent) and by philanthropic or other sources (1.3 percent).

(*b*) Private health insurance paid 35.8 percent of patient's expenditures for hospital care, 39 percent of the cost of physicians' services, 9.8 percent of dentists' services, 6.5 percent of drugs and drug sundries, and 3.8 percent of all other services.

*Percentage of under age 65 civilian population with private health insurance coverage, as of Dec. 31, 1974*

| | *Percent* |
|---|---|
| Hospital care | 79.9 |
| Surgery | 78.3 |
| Physicians' in-hospital visits | 77.5 |
| X-ray and laboratory examinations | 77.5 |
| Visiting nurse service | 70.1 |
| Private duty nursing | 72.9 |
| Out-of-hospital prescribed drugs | 73.2 |
| Physicans' home and office visits | 62.3 |
| Nursing home care | 35.2 |
| Dental care | 17.4 |

*Number of persons under age 65 covered by private health insurance, by type of plan*

| | *Millions* |
|---|---|
| Blue Cross and Blue Shield | 76 |
| Commerical insurance companies | 108 |
| Other (independent) plans | 9 |

*Income and expenses of all private health insurance organizations, 1974*

| | *Billions* |
|---|---|
| Premium income | $28.4 |
| Benefits paid (87 percent of premium income) | 24.8 |
| Operating expense (14 percent of premium income) | 3.9 |

### *Income and expenses of Blue Cross-Blue Shield plans, 1974*

| | *Billions* |
|---|---|
| Premium income | $12. 3 |
| Benefits paid (94 percent) | 11. 6 |
| Operating expense (7 percent) | . 9 |

### *Income and expenses of commercial health insurance companies, 1974*

| | |
|---|---|
| Total premium income (billions of dollars) | [1] 13. 8 |
| Group insurance benefits paid (percent of premium income) | 90. 6 |
| Individual insurance benefits paid (percent of premium income) | 46. 3 |
| Group insurance operating expense (billions of dollars) | 1. 4 |
| Individual insurance operating expense (billions of dollars) | 1. 5 |

[1] Of this amount, 24 percent came from individual policies and 76 percent came from group business.

For all commercial insurance policies, operating expense amounted to 21 percent of premium income. Individual business had a net underwriting gain of 6.7 percent of premium income, and group business showed a net underwriting loss of 3.6 percent.

### *Income and expenses of other plans*

| | |
|---|---|
| Total premium income (billions) | $2. 1 |
| Benefits paid (percent) | 93. 2 |
| Operating expense (percent) | 7. 6 |

### *Public Programs (fiscal year 1975)*

| | *Billions* |
|---|---|
| All public programs | $45. 6 |
| Federal programs | 31. 0 |
| Medicare (includes administrative costs of $660.6 million) | 15. 0 |
| Medicaid (Federal funds only; includes administrative costs) | 7. 0 |
| Defense Department hospital and medical care (including military dependents) | 3. 0 |
| Veterans' hospital and medical care | 3. 2 |
| State and local programs (including State share of medicaid program) | 15. 0 |

### *Financial experience of private health insurance organizations, 1974*

[Amounts in millions]

| | | Benefits paid | | Operating expenses | | |
|---|---|---|---|---|---|---|
| | Premium income | Amount | Percent of income | Amount | Percent of premium income | Net underwriting loss or gain |
| Total | 28. 4 | 24. 8 | 87. 2 | 3. 9 | 14. 1 | −0. 3 |
| Blue Cross | 8. 6 | 8. 3 | 96. 1 | . 4 | 5. 4 | −. 2 |
| Blue Shield | 3. 7 | 3. 3 | 89. 5 | . 4 | 11. 8 | −. 04 |
| Commercial group | 10. 6 | 9. 6 | 90. 6 | 1. 3 | 13. 0 | −. 3 |
| Commercial individual | 3. 2 | 1. 5 | 46. 3 | 1. 5 | 47. 0 | 6. 7 |
| All other plans | 2. 2 | 2. 0 | 93. 2 | . 1 | 7. 6 | −. 08 |

## Major Medical Insurance

### COMMERCIAL INSURANCE COMPANIES

*Major medical plans*

Major medical plans offered by commercial insurance companies are of two types: (*a*) Supplementary, which supplement plans of basic benefits, and (*b*) comprehensive, which have no basic coverages and furnish a complete and integrated coverage in one package. The first type covers more people than the second by a ratio of nearly 3 to 1.

*Supplementary plans*

Supplementary plans typically pay 80 percent of covered expenses over and above the expenses covered under a basic plan, and after the payment of a deductible, up to a specified maximum benefit computed on an illness basis, or dollar limit per year or lifetime.

### BLUE CROSS-BLUE SHIELD

*Major medical plans*

Major medical plans offered by Blue Cross-Blue Shield are of the supplementary type. Supplementary "major medical" contracts are similar to those sold by insurance companies. They provide coverage of hospital care and physicians' services in the office, home, and hospital (in addition to benefits under the basic Blue Cross-Blue Shield contract), drugs, appliances, private-duty and visiting-nurse service, and sometimes nursing home care—all on a deductible and coinsurance basis (that is, payment after an initial deductible of 75 percent or 80 percent of covered expenses).

"Extended benefit" contracts generally provide additional hospital coverage for days beyond the basic contract and coverage of physicians' services and, possibly, drugs after hospitalization. In many cases they also provide some coverage of outpatient diagnostic X-ray and laboratory service, visiting-nurse service, and, in lesser degree, nursing home care.

Blue Cross-Blue Shield developed these policies in a competitive response to the commercial health insurance industry, which were the first to develop such policies.

## Regulation of Private Health Insurance[1]

### A. BASIS FOR STATE REGULATION

Health insurance, like other kinds of private insurance, historically has been regulated by State, not Federal law. In 1944, the Supreme Court reversed its traditional position toward the business of insurance by declaring, in *U.S.* v. *South Eastern Underwriters Association*, 322 U.S. 533, that insurance transactions across State lines are in interstate commerce. This decision led to action by the Congress to maintain State regulation. Public Law 15, 59 Stat. 33, enacted on March 9, 1945, states "That the continued regulation and taxation by the several states of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States * * * The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." The act also provided, however, that, effective in 1948, Federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by State law."

In order to avoid possible Federal action to regulate the industry the National Association of Insurance Commissioners and the industry collaborated in writing new or stronger State laws, including some suggested uniform State insurance acts. Considerable variation among the States in their regulation of the insurance industry still exists, however, with respect to basic State law and to characteristics of administration by State insurance departments. Some of these differences are described in the remainder of this section.

### B. HEALTH INSURANCE CARRIERS

Most State insurance laws refer only to life or casualty insurance companies, either of which may write health insurance. A company wishing to carry health insurance only usually incorporates either as a life or a casualty insurance company and must meet the statutory requirements for that category of company. In 1970, there were 916 companies in the health insurance field, with 327 companies doing about 96 percent of the health insurance business.[2]

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[1] Based on Library of Congress, Congressional Research Service study, "State Regulation of Private Health Insurance," May 1, 1972.

Each commercial company is required to incorporate in its State of domicile and meet initial minimum solvency standards before transacting business. The specific requirements, usually involving specified amounts of paid-in capital, or initial free surplus, or both, vary widely depending on a variety of factors such as the kind of company involved (whether it is a stock or mutual company), how the company is organized (is it a domestic, foreign or alien insurer), the number and/or combination of insurance lines that the company will or does offer, and the length of time during which the insurer has had actual experience in a particular insurance line or in the business of insurance generally. Each insurer must satisfy comparable requirements in each State in which it desires to do business. Its financial statements, reserves and investments are subject to control by the State of domicile and by the States in which policies are issued. Policy forms must also be submitted for approval in the States in which they are issued and policy language must conform to the requirements of State law.

### C. REGULATION OF POLICY FORMS

Use of a single standardized health insurance form by all companies in the business has never been required by law or achieved through industry practice, as has occurred in fire and automobile insurance. Every State requires that individual policy forms must be filed with and reviewed by the insurance commissioner before being used, and 45 jurisdictions require filing of group forms. Insurance codes generally authorize the commissioner to disapprove a policy if it contains one or more provisions which are "unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation * * *" In the case of individual contracts the codes also require inclusion in substance of 12 required and 11 optional policy provisions which have been adopted by every State, after being approved in 1950 by the National Association of Insurance Commissioners.

The 12 uniform provisions required to be included in every individual health insurance policy deal with such matters as the method of giving notice of claim and proof of loss, cancellation and reinstatement rights, the grace period for paying premiums and making changes of beneficiary, and the time and method of paying claims. The 11 optional provisions pertain to prorating benefits in the event of a change of occupation, results of misstatement of age, or the existence of other insurance covering the same loss, and also include an optional 5-day cancellation provision. Two of the optional provisions touch on policy exclusions, since they permit the insurer to exclude losses attributed to the insured's engaging in an illegal occupation, committing a felony, or being intoxicated or under the influence of narcotics.

Except for these two optional provisions, the uniform policy provisions required by law do not affect coverage, exclusions or benefit levels. An insurer may (1) combine coverages in any way; (2) include or exclude inhospital surgical or medical care, ambulance, anesthesia or other services with hospital insurance; (3) use any relationship between the hospital room and board benefit and the allowance for miscellaneous services, or make them independent; and

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[2] Of these, 701 are life companies and 215 are casualty insurers.

(4) offer any level of hospital daily benefit, any maximum period of coverage, and any schedule of surgical or ancillary benefits.

In group health insurance 32 jurisdictions prescribe some requirements. These usually include such items as (1) provision for issuing certificates to employees; (2) provision that statements are representations and not warranties; (3) rules concerning remittance of premiums; (4) provisions for adding new employees; and (5) provisions for dealing with proofs of loss and payment of claims.

### D. PREMIUM RATES

Health insurance premium rates are not regulated by State insurance departments, although many jurisdictions require the filing of such rates. The reason usually given for the lack of premium rate regulation in the health insurance field is that such regulation is neither needed nor justified because of the highly competitive market in which health insurance, and particularly group health insurance, is sold; the argument is that the market itself serves to keep rates and benefits competitive. (The basic reason why States are active in rate regulation in property and casualty insurance areas is that these companies sought and received exemption from antitrust laws, and, in view of the practice of rate-making in concert, regulation of rates by State insurance departments was needed to prevent monopolistic practices.)

Under their authority to disapprove health insurance policy forms, however, about half of the States permit their insurance commissioners to disapprove a policy form, usually on grounds that the benefits provided are unreasonable in relation to the premium charged, or the policy contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation.

An insurer must submit to any State insurance department requesting the information the loss ratio [3] of each health insurance policy form. This information provides data which can be used to determine whether benefits are reasonable in relation to premiums, that is, whether premium rates are so high as to result in very low loss ratios. The National Association of Insurance Commissioners, in an effort to establish guidelines for applying this provision, has adopted a general benchmark of a 50-percent loss ratio. By implication, any policy form which, over a substantial period of time, pays out in benefits less than 50 percent of premiums collected offers "benefits unreasonable in relation to the premium charged." This standard is difficult to enforce, since experience over several years is generally needed to determine whether a policy form really has a loss ratio of less than 50 percent and it is obviously of limited usefulness in the case of new policy forms.

### E. BENEFIT LEVELS IN INDIVIDUAL HEALTH INSURANCE POLICIES

State laws are almost completely silent on the question of the adequacy of the benefits offered by individual health insurance policies to the needs of the policyholder. A committee of the National Association of Insurance Commissioners studied the question of whether minimum benefit legislation should be recommended, but was discharged in 1952 without proposing any model legislation. Only California, with its 1949 minimum benefits law, attempts to require that health insurance policies provide benefit levels which meet certain minimum standards. New Jersey has through administrative action ruled out one-disease-only and similar contracts.

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[3] Loss ratio here means the ratio of benefits paid out to premiums collected.

The absence of such standards has resulted in issuance by some insurers of policies providing clearly inadequate amounts of coverage for the risks of daily hospital costs, fragmentation of protection into unrealistically low itemization of costs for specific services such as X-rays, laboratory tests, oxygen, et cetera, and medical expense benefits that cover a small fraction of the cost of physicians and other services. In addition, there has been increased promotion of one-disease-only, or accident-and-one-disease policies. The number of different health insurance policies written in the United States today probably approaches 10,000. The combinations are infinite.

As a result of the great number of different possible combinations of benefit amount, length of stay, ancillary benefits and surgical schedules, often combined with a great variety of income coverage for loss of time because of accident or sickness, health insurance has become the most heterogeneous and confusing type of insurance. It is extremely difficult, if not impossible, for the purchaser of an individual health insurance policy to compare benefits and costs and to shop intelligently among those available. The task is further complicated by the existence of different classifications of policies such as guaranteed renewable, conditionally renewable, and cancellable, with different levels of cost, and with specific maeanings of these terms as used in the industry not necessarily clear to the potential purchaser. (Definitions of these terms can be found on p. 218.)

### F. GROUP INSURANCE ELIGIBILITY REQUIREMENTS

State laws defining group health insurance and the minimum size of a group follow generally the model group accident and health insurance bill recommended by the National Association of Insurance Commissioners, but many vary in form. The New York law, as an example, defines six different kinds of groups, each with different requirements as to minimum size and participation requirements. New York differentiates among group health insurance policies issued to an employer, a trade association, a labor union or other employee association, a multiemployer or joint union-employer welfare fund, a creditor group, and a public welfare district. Each of these six classes, which are the only types of groups to which group insurance may be issued must meet certain specified requirements, such as: (1) the group must have been formed for a purpose other than obtaining insurance; (2) the minimum number of covered persons in a group varies from two for an employer-employee group to 100 for the employees or members of a trade association, the number increasing as the group becomes less homogeneous and more likely to include persons who joined just to get the insurance; (3) the amount of coverage must usually be based on a plan which precludes individual selection; and (4) if the employer contributes to the cost of the insurance, at least 75 percent of the employees must agree to purchase it, while an employer who pays the entire cost must insure all of his employees, or all those belonging to the class (for example, white collar or clerical employees) covered by the policy.

On the one hand, it has been held by some that liberalization of State laws defining a group to make group health insurance more widely available might result in broader and less expensive coverage for many people, since the 90-percent loss ratio common in group hospital and medical insurance shrinks to between 50 and 60 percent in individual policies. On the other hand, the fact that, in the 16 or so States without statutory definitions of group health insurance, the types of groups written do not differ greatly from those in the States with legal restrictions, indicates that the underwriting rules in laws like

New York's are safeguards which any prudent insurer is likely to adopt. Moreover, the lower loss ratios on group health insurance are probably accounted for, in part, by the amount of administrative and claims work done in large groups by the employer, rather than the carrier. This helps account for the fact that large group contracts are relatively inexpensive for the carrier to administer with premiums only 5 to 10 percent higher than the cost of the claims incurred. This would not, of course, be true in very small groups, or in nonemployer employee groups in which the insurer had higher administrative costs in collecting premiums and processing claims.

### G. REGULATION OF MAIL-ORDER INSURERS AND HEALTH INSURANCE ADVERTISING

Mail-order selling of health insurance is more widespread than in other forms of insurance, almost all of it for individually written health insurance policies. Until 1950 mail-order insurers could incorporate in one State and then operate, free of regulation, in all the others. If the State of incorporation was one with lax insurance statutes, a mail-order company could escape effective regulation of any kind and, in addition, avoid taxation by all States other than the State of domicile. This situation has changed somewhat since 1950, when the U.S. Supreme Court upheld Virginia's right to assert jurisdiction over a Nebraska mail-order company by ordering it to cease and desist from solicitation or sale of policies to Virginia residents unless it obtained authority in accordance with Virginia law (*Travelers Health Association* v. *Virginia*, 339 U.S. 643).

Most States have also adopted the Unauthorized Insurers Service of Process Act, recommended by the National Association of Insurance Commissioners, which provides that any insurer doing business in a State, by mail or otherwise, automatically designates the State insurance commissioner as his agent for service of process, and that service of process on the commissioner gives the State courts jurisdiction over the mail-order insurer.

Some State insurance departments have tried to eliminate mail-order insurers by asking local news media to refuse advertising from unauthorized insurers and by issuing periodic press releases warning the public to check with the insurance department before buying insurance by mail.

Wisconsin has levied a special premium tax on unauthorized insurers at a higher rate than on authorized insurers and the courts have upheld its constitutionality. In California, too, mail-order insurance has been held by the courts to be subject to regulation, based on a suit by the California insurance commissioner to prevent three companies from doing business in the State without obtaining a certificate of authority.

In 1954, the Federal Trade Commission cited a number of insurance companies for false and misleading advertising of health insurance policies. The States responded to the Federal Trade Commission's initiative by adopting a set of rules governing insurance advertising drafted by an all industry committee of representatives of the companies and State insurance departments. The U.S. Supreme Court held, when the first of these Federal Trade Commission cases reached it in 1957, that the McCarran Act of 1945 "withdrew from the Federal Trade Commission the authority to regulate respondents' advertising practices in those States which are regulating those practices under their own laws." (*F.T.C.* v. *National Casualty Company*, 337 U.S. 560.)

The U.S. Supreme Court subsequently ruled, however, in 1960 that the existence of State laws regulating advertising did not nullify the FTC's jurisdiction over mail-order insurance, on the grounds that the State in which policies are sold has no effective way of regulating the activities of out-of-State mail-order companies. In 1964, the FTC issued its Guides for the Mail Order Insurance Industry.

The legal authority of the States to regulate insurer advertising is based on the Uniform Trades Practices Act, adopted by every State soon after enactment of the McCarran Act in 1945. These acts, intended to "regulate trade practices in the business of insurance" define and prohibit practices "which constitute unfair methods of competition or unfair or deceptive acts or practices." Among other unfair trade practices, "misrepresenting the terms of any policy issued or the benefits or advantages promised thereby," and "publishing * * * an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance * * * which is untrue, deceptive or misleading" are prohibited. This same Uniform Trades Practices Act contains an antidiscrimination section pertaining to health insurance which prohibits "permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium * * * or rates charged."

### H. DUPLICATION OF COVERAGE AND SUBROGATION

Duplication of benefits can occur when a person covered under more than one health or accident insurance policy collects payments for the same hospital or medical expenses from more than one insurer. State laws recognize this situation in the area of possible duplication between individual health insurance contracts by providing, in four of the optional uniform provisions which may be included in individual health insurance policies, against overinsurance due to two similar policies issued by the same insurer; loss-of-time coverage in excess of the insured's monthly earnings; and duplicate coverage with other insurers.

Antiduplication clauses appear also in some group insurance policies, primarily major medical, but there remains the problem of duplication between Blue Cross and group health insurance, or between either group insurance or Blue Cross and individual policies.

In addition to the duplication between different types of hospital and medical expense coverage, there is also overlap between health insurance policies and automobile liability insurance and medical payments coverage enabling injured persons in many cases to collect the same medical expense costs from more than one insurance carrier.

It is of interest in this regard that the proposed Federal Uniform Motor Vehicle Insurance Act (S. 945, 92d Congress, 1st sess.) provides that an individual's reimbursement for his economic loss due to automobile accident injury would be reduced by the amount of any benefits or payments to which he is entitled for the same injury "under any private or public insurance or plan or other source of benefits." This provision would make insurance carriers and public programs other than automobile insurance companies the primary sources of payment for motor vehicle injuries, with the automobile insurance carrier responsible only for the "net economic loss" remaining after the other benefits are paid.

The Civil Service Commission and the Department of HEW have expressed reservations about this aspect of the proposed Uniform Motor Vehicle Insurance Act, insofar as it would make the Federal employees health benefits program and medicare, rather than the no-fault insurance, the primary source of payments for motor vehicle injuries. They recommended that there be subrogation among insurance carriers to insure prompt payment of medical expenses without duplication of benefits. Their position is that when a motor vehicle accident results in injury, the motor vehicle insurance should bear the expenses, with the Federal employees health benefits program and medicare paying any medical costs not paid for by the motor vehicle insurance.

It is considered desirable by some insurance experts that private health insurance, including Blue Cross or group hospital insurance, should have subrogation rights similar to those in most automobile, fire, and other types of property insurance policies. The health insurance company or plan, having paid a policyholder's hospital bill, could then assume his right to sue, if the accident causing his hospitalization were due to someone's negligence, and be reimbursed for its outlay. (The Michigan Supreme Court has ruled that common law and equitable principles of subrogation did not permit the Michigan Blue Cross to exercise subrogation rights, even if its policyholder collected, in a liability suit, for the hospital bills Blue Cross had paid (*Michigan Hospital Service* v. *Sharpe*, 339 Mich. 357, 63 N.W.2d, 638, 1954). However, Michigan Blue Shield was permitted to recoup the amount it had paid for medical expenses for the same individual because Blue Shield, unlike Blue Cross, had a subrogation clause in its contract.)

### *Cancellation*

One of the optional provisions which may be included in individual health insurance policies, at the insurer's option, is a clause permitting the insurer to cancel the policy on 5 days' notice. Cancellation would not affect a benefit that had already been furnished, but would protect the carrier from having to pay future claims for an individual whose past claims history indicates that he may be a substandard risk. Some States have enacted legislation prohibiting cancellation of health insurance contracts between policy anniversaries, in order to prevent cancellation at a time when the person may most need the coverage.

Even though most insurers do not exercise the right to put a cancellation provision in individual health insurance policies, most health insurance policies are annual contracts so that absence of a cancellation clause merely guarantees protection for 1 year. An insurer may refuse to renew the policy after its expiration date in the case of a person whose health has deteriorated since the policy was purchased or who has chronic ailments that might require future expensive medical care, in the absence of a statute or policy provision limiting this right. Or as an alternative, the carrier may offer to renew the policy but only with a rider excluding the condition most likely to require medical care.

New York State has a statutory safeguard against the right of insurers to refuse renewal which prohibits an insurer from refusing to renew, after 2 years from the date of issuance, any hospital or medical expense insurance policy "because of a change in the physical or mental condition or the health of any person covered thereunder"; restrictive riders are also prohibited.

Some 10 other States do not permit an insurer to write policies cancelable on 5 (or 10 or 30) days' notice, while some require that any right by the insurer to cancel or refuse renewal be stated prominently on the face of the policy.

Categorized according to increasing policyholder security as to renewability, there are currently five types of hospital and medical expense contracts sold in the United States:

(*a*) Cancelable policies, giving the insured or the insurer the right to cancel at any time, on 5 days' written notice. This type, formerly prevalent, is now relatively rare, due primarily to competition rather than statute.

(*b*) Renewable at the option of the company. These cannot be canceled between anniversary dates, but the insurer has the right to renew or not, at its option, on any anniversary. (The insured can also exercise this right by neglecting to pay the next year's premium.)

These two types, characterized by relatively modest short-term benefits, have made up the bulk of commercial policies, but the trend has been in the direction of contracts providing broader and longer term benefits, with restrictions on the carrier's right to refuse renewal.

(*c*) Conditionally renewable policies, which restrict the company's right to cancel or refuse to renew an individual policy, but permit it to refuse renewal of an entire class of policies. This type of "renewal guarantee" clause usually defines what is meant by refusal to renew a class of policies; for example, the right to refuse renewal of all policies issued on the same policy form to persons residing in the same State, or enumerating certain reasons, such as the health of an individual, which the insurer cannot use as grounds for refusal to renew. This type of policy protects only against nonrenewal at the same premium, but does not prevent the insurer from raising the premium rate—but only for the whole class of insureds, not for any individual policyholder.

(*d*) Guaranteed renewable. These policies, usually written by life insurance companies, provide broad long-term benefits and completely eliminate the insurer's right to cancel or refuse renewal. Most such policies terminate at age 65 especially since the advent of medicare; and the insurer has the right to increase premiums for all policies in a class, but not for any individuals in the class.

(*e*) Noncancelable. This term, in industry usage, is reserved for policies that guarantee not only the right to renew, but the right to renew at a specific premium. Few such policies include hospital or medical care coverage, because of their rising costs from year to year.

## I. REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS

### *Number of Plans*

There are 75 Blue Cross and 71 Blue Shield plans in the United States.

### *Regional and State Variation in Enrollment*

Blue Cross-Blue Shield plans are strongest in the New England and Middle Atlantic States, where these plans cover about half of the population under hospital and surgical-medical benefits.

The plans are weakest in the West South Central States, where only about 20 percent of the population is enrolled for hospital and surgical-medical benefits.

In the Pacific, Mountain, and South Atlantic States, the plans cover about 25 percent of the population.

### *Organization*

The 75 separate Blue Cross plans in the United States are each individual organizations, providing hospital insurance in a specific geographical area, usually a State or part of a State. The plans are interconnected, however, through the national Blue Cross Association, which represents them in national affairs and provides certain marketing, research, and professional and public relations services, and operates both an interplan bank that arranges coverage for subscribers who use hospital services outside the area of their own plan, and an interplan transfer agreement to facilitate transfer of coverage for subscribers who move permanently from one area to another.

The Blue Cross Association also operates a stock insurance company, Health Service, Inc., which offers a uniform contract for groups whose employees and activities are located in areas served by more than one plan. The capital to organize Health Service, Inc.—initially $200,000 with $282,000 surplus—was contributed in 1949 by certain Blue Cross plans, and the directors of the company are selected largely by these plans with a minority chosen by the Blue Cross Association. Earnings go to the association.

Blue Shield plans are also organized on a geographical basis, usually in the same areas as Blue Cross. Blue Cross and Blue Shield share common administrative arrangements in many plan areas. They are similarly linked by the National Association of Blue Shield Plans, which serves them in somewhat the same way that the Blue Cross Association serves its constituent plans, and also operates its own stock insurance company, Medical Indemnity of America, Inc., for national accounts.

### *Administrative Organization*

Blue Cross and Blue Shield plans are governed by boards of directors chosen from among representatives of hospitals, the medical profession, and the public. Boards of directors are not elected by subscribers; they are either self-perpetuating or, in the case of many Blue Cross plans, chosen by a special "corporation" comprised of individuals from various businesses and professions, particularly hospitals and local medical societies. In Blue Shield plans, physicians commonly are appointed to the boards directly by State or county medical societies.

The boards of directors have general policymaking authority, elect the plan's officers, and control appointment of the managing director and major committees.

The managing director, usually called the executive director, oversees the plan's operations in enrollment, ratemaking and underwriting, accounting, service to subscribers, hospital and professional relations, and public relations.

Over the years, much discussion and controversy have occurred with regard to the proper makeup of boards of directors of the Blue plans. State laws are not consistent in providing for representation of the public on these boards, nor in specifying what form such representation should take. While hospital representatives have tended to dominate Blue Cross boards, and physicians those of Blue Shield, some public representation is provided for. However, the manner of selection of these public representatives leaves room for some question as to the extent to which they represent the plans' subscribers, or other community interests. Questions have also been raised as the propriety of large insurance enterprises like Blue Cross and Blue Shield being controlled by the organizations and individuals that sell services to them—that is, hospitals and physicians—rather than directly by those who pay for and use those services—that is, the plan's subscribers, both employers and employee groups (as well as individuals not in groups). For example, only recently has the Blue Cross

Association and the American Hospital Association taken steps to reduce duplication on the two boards of directors and for ownership of the Blue Cross symbol to be transferred from the American Hospital Association to the Blue Cross Association.

*Regulation*

Blue Cross and Blue Shield plans are established in most States under special enabling acts which exempt them from the usual capital reserve requirements to which commercial insurance companies are subject, as well as from State and local taxation on income or assets, but not from regulation. Some 44 States have laws regulating Blue Cross plans—in 41 of them by the State insurance department. The great majority of Blue Shield plans are also regulated by State insurance commissioners; a notable exception is the California Physicians' Service (Blue Shield of California) which is under the sole jurisdiction of the State attorney general (as the result of a court ruling which held it to be a nonprofit organization outside the scope of the insurance laws, leaving it essentially unregulated).

The regulatory areas in which Blue Cross and Blue Shield plans are treated very much like other types of health insurance companies include permits to commence operations, approval of benefit structures, investment limitations, advertising procedures, and reporting and examination requirements. Blue Cross and Blue Shield associations are generally regulated less stringently than insurance companies in the areas of taxation, capital and surplus requirements, reserve standards, and licensing of sales representatives. The subscriber rates of the plans are supervised more closely than are commercial health insurance companies, which generally do not have their premiums reviewed by insurance commissioners. Other features which characterize Blue plans, but generally not insurance companies, are public hearings on rate changes, benefit modifications, reimbursement, and fee schedules. In most cases, also, they must confine their operations within specified territorial boundaries and conform to certain expense limits.

In addition to meeting State statutory and administrative requirements, Blue Cross and Blue Shield organizations must comply with the provisions of approval programs administered by their national associations, which may be stricter than those imposed by State law and regulation.

The laws of many States establish some form of ratemaking machinery for Blue Cross and Blue Shield. The statutory language used in State laws is usually quite general, and rarely if ever, includes any detailed criteria for determining how rates are to be approved. Connecticut's hospital service corporation contains language typical of that found in many State laws regarding rates:[4]

> No such corporation shall enter into any contract with subscribers unless and until it has filed with the insurance commissioner a full schedule of the rates to be paid by the subscribers and has obtained said commissioner's approval thereof. The commissioner may refuse such approval if he finds such rates to be excessive, inadequate, or discriminatory.

At the same time, many of the States also require that the rates of payment to participating hospitals and physicians are to be "fair and reasonable" or "adequate and reasonable" [5] The list following indicates which of the States have premium rate approval requirements for the Blue plans.[6]

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[4] General Statutes of Connecticut, section 33–166.

[5] Alaska Insurance Statutes, section 21.87.190.

[6] From data supplied by the National Association of Insurance Commissioners as modified by information obtained from individual States.

## *Rate Approval Requirements of Blue Cross and Blue Shield Plans

### STATE AND REQUIREMENT

Alabama—Yes
Alaska—Yes
Arizona—No
Arkansas—No
Colorado—Yes
Connecticut—Yes
District of Columbia—No regulation
Florida—Yes
Hawaii—No
Idaho—Yes
Illinois—Yes
Indiana—Regulated under insurance laws
Iowa—Yes
Kansas—Yes
Kentucky—Yes
Maryland—Yes
Massachusetts—Yes
Michigan—Yes
Minnesota—Yes
Missouri—No regulation
Montana—No
Nevada—No
New Hampshire—Yes
New Jersey—Yes
New Mexico—Yes
New York—Yes
Ohio—No
Oregon—No
Rhode Island—Yes
South Carolina—Regulated under insurance laws
South Dakota—Yes
Texas—Yes
Utah—No
Vermont—No
Virginia—No
Wisconsin—No
Wyoming—Regulated under insurance laws

TABLE 1.—*Estimates of net number of different persons under private health insurance plans and percent of population covered, by age and specified type of care, as of Dec. 31, 1974*

| Type of service | All ages | | Under age 65 | | Aged 65 and over | |
|---|---|---|---|---|---|---|
| | Number (in thousands) | Percent of civilian population [1] | Number (in thousands) | Percent of civilian population [2] | Number (in thousands) | Percent of civilian population [3] |
| Hospital care | 163, 396 | 77. 6 | 150, 585 | 79. 9 | 12, 811 | 57. 9 |
| Physicians services: | | | | | | |
| Surgical services | 159, 518 | 75. 7 | 147, 570 | 78. 3 | 11, 948 | 54. 0 |
| In-hospital visits | 155, 022 | 73. 6 | 146, 110 | 77. 5 | 8, 912 | 40. 3 |
| X-ray and laboratory examinations | 153, 017 | 72. 7 | 146, 006 | 77. 5 | 7, 011 | 31. 7 |
| Office and home visits | 125, 183 | 59. 4 | 117, 321 | 62. 3 | 7, 862 | 35. 5 |
| Dental care | 33, 297 | 15. 8 | 32, 887 | 17. 4 | 410 | 1. 9 |
| Prescribed drugs (out-of-hospital) | 141, 755 | 67. 3 | 138, 023 | 73. 2 | 3, 732 | 16. 9 |
| Private-duty nursing | 141, 167 | 67. 0 | 137, 446 | 72. 9 | 3, 721 | 16. 8 |
| Visiting-nurse service | 136, 687 | 64. 9 | 132, 044 | 70. 1 | 4, 643 | 21. 0 |
| Nursing-home care | 69, 840 | 33. 2 | 66, 343 | 35. 2 | 3, 497 | 15. 8 |
| HIAA estimates: | | | | | | |
| Hospital care | 171, 760 | 81. 6 | 160, 483 | 85. 2 | 11, 277 | 51. 0 |
| Surgical services | 162, 571 | 77. 2 | 153, 346 | 81. 4 | 9, 225 | 41. 7 |

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[1] Based on Bureau of the Census estimate of 210,593,000 as of Jan. 1, 1975.

[2] Based on Bureau of the Census estimate of 188,467,000 as of Jan. 1, 1975.

[3] Based on Bureau of the Census estimate of 22,126,000 as of Jan. 1, 1975.

TABLE 2.—*Gross enrollment under private health insurance plans for persons of all ages, by type of plan and specified type of care, as of Dec. 31, 1974*

[In thousands]

| Type of plan | Hospital care | Physicians' services |  |  |  | Dental care | Prescribed drugs (out-of-hospital) | Private duty nursing | Visiting-nurse service | Nursing-home care | Vision care |
|---|---|---|---|---|---|---|---|---|---|---|---|
|  |  | Surgical services | In-hospital visits | X-ray and laboratory examinations | Office and home visits |  |  |  |  |  |  |
| Total enrollment | 207,895 | 194,576 | 191,429 | 181,634 | 150,612 | 33,297 | 148,731 | 148,113 | 148,382 | 71,202 | (1) |
| Blue Cross-Blue Shield | 83,845 | 76,878 | 74,847 | 64,240 | 34,854 | 3,790 | 40,329 | 38,785 | 31,297 | 38,108 | 1,446 |
| Blue Cross | 81,399 | 4,289 | 3,785 | (1) | 1,261 | (1) | (1) | (1) | (1) | (1) | (1) |
| Blue Shield | 2,446 | 72,634 | 71,062 | (1) | 33,598 | (1) | (1) | (1) | (1) | (1) | (1) |
| Insurance companies | 114,566 | 105,164 | 104,898 | 105,142 | 103,804 | 16,842 | 103,095 | 103,075 | 103,075 | 29,025 | (1) |
| Group policies | 85,759 | 86,630 | 97,317 | 97,894 | 96,593 | 16,756 | 95,840 | 95,840 | 95,840 | 23,960 | (1) |
| Individual policies | 28,807 | 18,534 | 7,581 | 7,248 | 7,211 | 86 | 7,235 | 7,235 | 7,235 | 5,065 | (1) |
| Independent plans | 9,484 | 12,539 | 11,684 | 12,252 | 11,954 | 12,665 | 5,327 | 8,253 | 9,010 | 4,069 | 6,636 |
| Community | 3,638 | 6,110 | 6,110 | 6,010 | 6,020 | 1,211 | 1,796 | 4,830 | 5,400 | 1,600 | 4,200 |
| Employer-employee-union | 5,695 | 6,275 | 5,420 | 6,088 | 5,760 | 1,900 | 3,500 | 3,403 | 3,600 | 2,363 | 2,294 |
| Private group clinic | 151 | 154 | 154 | 154 | 154 | 54 | 31 | 20 | 10 | 106 | 142 |
| Dental service corporation |  |  |  |  |  | 9,500 |  |  |  |  |  |

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[1] Data not available.

TABLE 3.—*Gross enrollment under private health insurance plans for persons under age 65, by type of plan and specified type of care, as of Dec. 31, 1974*

[In thousands]

| Type of plan | Hospital care | Physicians' services |  |  |  | Dental care | Prescribed drugs (out-of-hospital) | Private duty nursing | Visiting-nurse service | Nursing-home care | Vision care |
|---|---|---|---|---|---|---|---|---|---|---|---|
|  |  | Surgical services | In-hospital visits | X-ray and laboratory examinations | Office and home visits |  |  |  |  |  |  |
| Total enrollment | 192,467 | 182,960 | 181,324 | 173,747 | 140,785 | 32,887 | 144,924 | 144,318 | 138,646 | 67,670 | (1) |
| Blue Cross-Blue Shield | 75,992 | 69,838 | 68,012 | 60,127 | 28,238 | 3,699 | 38,880 | 35,433 | 29,129 | 35,468 | 1,157 |
| Blue Cross | 73,798 | 3,830 | 3,492 | (1) | 1,187 | (1) | (1) | (1) | (1) | (1) | (1) |
| Blue Shield | 2,194 | 66,008 | 64,520 | (1) | 27,051 | (1) | (1) | (1) | (1) | (1) | (1) |
| Insurance companies | 107,602 | 101,288 | 102,340 | 102,080 | 101,272 | 16,578 | 101,065 | 101,065 | 101,065 | 28,425 | (1) |
| Group policies | 84,234 | 85,170 | 95,222 | 95,023 | 94,237 | 16,492 | 94,047 | 94,047 | 94,047 | 23,512 | (1) |
| Individual policies | 23,368 | 16,118 | 7,118 | 7,057 | 7,035 | 86 | 7,018 | 7,018 | 7,018 | 4,913 | (1) |
| Independent plans | 8,873 | 11,834 | 10,972 | 11,540 | 11,275 | 12,610 | 4,979 | 7,820 | 8,452 | 3,777 | 6,182 |
| Community | 3,442 | 5,838 | 5,838 | 5,738 | 5,748 | 1,187 | 1,713 | 4,638 | 5,146 | 1,502 | 3,946 |
| Employer-employee-union | 5,299 | 5,863 | 5,001 | 5,669 | 5,394 | 1,871 | 3,255 | 3,165 | 3,296 | 2,178 | 2,107 |
| Private group clinic | 132 | 133 | 133 | 133 | 133 | 52 | 11 | 17 | 10 | 97 | 129 |
| Dental service corporation |  |  |  |  |  | 9,500 |  |  |  |  |  |

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[1] Data not available.

TABLE 4.—*Gross enrollment under private health insurance plans for persons aged 65 and over, by type of plan and specified type of care, as of Dec. 31, 1974*

[In thousands]

| Type of plan | Hospital care | Physicians' services | | | | Dental care | Prescribed drugs (out-of-hospital) | Private duty nursing | Visiting-nurse service | Nursing-home care | Vision care |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Surgical services | In-hospital visits | X-ray and laboratory examinations | Office and home visits | | | | | | |
| Total enrollment | 15,428 | 11,616 | 10,105 | 7,887 | 9,827 | 410 | 3,807 | 3,795 | 4,736 | 3,532 | (1) |
| Blue Cross-Blue Shield [2] | 7,853 | 7,035 | 6,835 | [3] 4,113 | 6,616 | 91 | 1,449 | 1,352 | 2,168 | [3] 2,640 | 28 |
| Blue Cross | 7,601 | 409 | 293 | (1) | 74 | (1) | (1) | (1) | (1) | (1) | (1) |
| Blue Shield | 252 | 6,626 | 6,542 | (1) | 6,542 | (1) | (1) | (1) | (1) | (1) | (1) |
| Insurance companies | 6,964 | 3,876 | 2,558 | 3,062 | 2,532 | 264 | 2,010 | 2,010 | 2,010 | 600 | (1) |
| Group policies | 1,525 | 1,460 | 2,095 | 2,871 | 2,356 | 264 | 1,793 | 1,793 | 1,793 | 448 | (1) |
| Individual policies | 5,439 | 2,416 | 463 | 191 | 176 | ---------- | 217 | 217 | 217 | 152 | (1) |
| Independent plans | 611 | 705 | 712 | 712 | 679 | 55 | 348 | 433 | 558 | 292 | 45 |
| Community | 196 | 272 | 272 | 272 | 272 | 24 | 83 | 192 | 254 | 98 | 25 |
| Employer-employee-union | 396 | 412 | 419 | 419 | 386 | 29 | 245 | 238 | 304 | 185 | 18 |
| Private group clinic | 19 | 21 | 21 | 21 | 21 | 2 | 20 | 3 | ---------- | 9 | 1 |
| Dental service corporation | ---------- | ---------- | ---------- | ---------- | ---------- | 0 | ---------- | ---------- | ---------- | ---------- | ---------- |

[1] Data not available.
[2] Includes disabled persons under age 65.
[3] Mainly coverage of medicare deductibles.

**Table 5.**—*Percentage distribution of total gross enrollment under private health insurance plans, by age, type of plan, and specified type of care, as of Dec. 31, 1974*

| Age group and type of plan | Hospital care | Physicians' services | | | | Dental care | Prescribed drugs (out-of-hospital) | Private-duty nursing | Visiting-nurse service | Nursing-home care |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Surgical services | In-hospital visits | X-ray and laboratory examinations | Office and home visits | | | | | |
| Total, all ages | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Blue Cross-Blue Shield | 40.3 | 39.5 | 39.1 | 35.4 | 23.1 | 11.4 | 27.1 | 24.8 | 21.8 | 53.5 |
| Insurance companies | 55.1 | 54.0 | 54.8 | 57.9 | 68.9 | 50.6 | 69.3 | 69.6 | 71.9 | 40.8 |
| Group policies | 41.2 | 44.5 | 50.8 | 53.9 | 64.1 | 50.3 | 64.4 | 61.7 | 66.8 | 33.7 |
| Individual policies | 13.9 | 9.5 | 4.0 | 4.0 | 4.8 | .3 | 4.9 | 4.9 | 5.0 | 7.1 |
| Independent plans | 4.6 | 6.4 | 6.1 | 6.7 | 7.9 | 38.0 | 3.6 | 5.6 | 6.3 | 5.7 |
| Under age 65 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Blue Cross-Blue Shield | 39.5 | 38.2 | 37.5 | 34.6 | 20.1 | 11.2 | 26.8 | 24.6 | 21.0 | 52.4 |
| Insurance companies | 55.9 | 55.4 | 56.4 | 58.8 | 71.9 | 50.4 | 69.7 | 70.0 | 72.9 | 42.0 |
| Group policies | 43.8 | 46.6 | 52.5 | 54.7 | 66.9 | 50.1 | 64.9 | 65.2 | 67.8 | 34.7 |
| Individual policies | 12.1 | 8.8 | 3.9 | 4.1 | 5.0 | .3 | 4.8 | 4.8 | 5.1 | 7.3 |
| Independent plans | 4.6 | 6.5 | 6.0 | 6.6 | 8.0 | 38.3 | 3.4 | 5.4 | 6.1 | 5.6 |
| Aged 65 and over | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Blue Cross-Blue Shield | 50.9 | 60.6 | 67.6 | 52.1 | 67.3 | 22.2 | 38.1 | 35.6 | 45.8 | 74.7 |
| Insurance companies | 45.1 | 33.4 | 25.3 | 38.8 | 25.8 | 64.4 | 52.8 | 53.0 | 42.4 | 17.0 |
| Group policies | 9.9 | 12.6 | 20.7 | 36.4 | 24.0 | 64.4 | 47.1 | 47.2 | 37.9 | 12.7 |
| Individual policies | 35.2 | 20.8 | 4.6 | 2.4 | 1.8 | --------- | 5.7 | 5.7 | 4.6 | 4.3 |
| Independent plans | 4.0 | 6.1 | 7.0 | 9.0 | 6.9 | 13.4 | 9.1 | 11.4 | 11.8 | 8.3 |

TABLE 6.—*Hospital benefits: gross enrollment under private health insurance plans for persons of all ages and estimates of the net number of different persons covered, by type of plan, 1950–74*

[In thousands]

| End of year | Gross enrollments | | | | | | | | | | | | Net number of different persons covered, as estimated by— | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total | Blue Cross-Blue Shield | | | Insurance companies | | | Independent plans | | | | | Household surveys | | HIAA | |
| | | Total | Blue Cross | Blue Shield | Total | Group policies | Individual policies | Total | Community | Employer-employee-union | Medical society | Private group clinic | Number [1] | Percent of civilian population | Number | Percent of civilian population |
| 1950 | 81, 691 | 37, 645 | 37, 435 | 210 | 39, 601 | 22, 305 | 17, 296 | 4, 445 | 1, 445 | 2, 280 | 500 | 220 | | | | |
| 1955 | 113, 976 | 48, 924 | 47, 719 | 1, 205 | 58, 507 | 38, 620 | 19, 887 | 6, 545 | 2, 920 | 3, 220 | 360 | 45 | | | | |
| 1960 | 140, 055 | 57, 464 | 55, 938 | 1, 526 | 76, 597 | 54, 416 | 22, 181 | 5, 994 | 1, 604 | 4, 000 | 340 | 50 | | | | |
| 1965 | 160, 485 | 63, 662 | 61, 651 | 2, 012 | 89, 839 | 65, 415 | 24, 424 | 6, 984 | 1, 954 | 4, 971 | 8 | 51 | | | 138, 671 | 71. 9 |
| 1966 | 164, 958 | 65, 638 | 63, 408 | 2, 230 | 92, 687 | 67, 799 | 24, 888 | 6, 633 | 1, 964 | 4, 618 | | 51 | | | 142, 369 | 73. 2 |
| 1967 | 170, 636 | 67, 513 | 65, 188 | 2, 325 | 96, 073 | 71, 544 | 24, 619 | 7, 050 | 2, 300 | 4, 700 | | 50 | 145, 454 | 73. 9 | 146, 409 | 74. 4 |
| 1968 | 177, 138 | 70, 510 | 67, 958 | 2, 552 | 99, 351 | 74, 073 | 25, 278 | 7, 277 | 2, 507 | 4, 749 | | 20 | 150, 888 | 75. 9 | 151, 947 | 76. 4 |
| 1969 | 184, 808 | 73, 211 | 70, 620 | 2, 591 | 103, 895 | 77, 973 | 25, 922 | 7, 702 | 2, 672 | 5, 000 | | 30 | | | 155, 025 | 77. 2 |
| 1970 | 190, 758 | 75, 464 | 72, 942 | 2, 522 | 107, 163 | 80, 505 | 26, 658 | 8, 131 | 2, 900 | 5, 200 | | 31 | 154, 063 | 75. 9 | 158, 847 | 78. 2 |
| 1971 | 193, 308 | 76, 349 | 74, 383 | 1, 966 | 108, 414 | 80, 641 | 27, 773 | 8, 545 | 3, 100 | 5, 400 | | 45 | | | 161, 849 | 78. 8 |
| 1972 | 198, 132 | 78, 605 | 76, 322 | 2, 283 | 110, 537 | 81, 526 | 29, 011 | 8, 990 | 3, 370 | 5, 560 | | 60 | 155, 253 | 74. 9 | 164, 098 | 79. 2 |
| 1973 | 201, 684 | 81, 345 | 79, 199 | 2, 146 | 111, 170 | 83, 626 | 27, 544 | 9, 169 | 3, 538 | 5, 491 | | 140 | | | 167, 147 | 80. 0 |
| 1974 | 207, 895 | 83, 845 | 81, 399 | 2, 446 | 114, 566 | 85, 759 | 28, 807 | 9, 484 | 3, 638 | 5, 695 | | 151 | 163, 396 | 77. 6 | 171, 760 | 81. 6 |

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[1] Estimated by applying percentages to total civilian population.

TABLE 7.—*Surgical benefits: gross enrollment under private health insurance plans for persons of all ages and estimates of the net number of different persons covered, by type of plan, 1950–74*

[In thousands]

| End of year | Gross enrollments | | | | | | | | | | | | Net number of different persons covered, as estimated by— | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Blue Cross-Blue Shield | | | Insurance companies | | | Independent plans | | | | | Household surveys | | HIAA | |
| | Total | Total | Blue Cross | Blue Shield | Total | Group policies | Individual policies | Total | Community | Employer-employee-union | Medical society | Private group clinic | Number[1] | Percent of civilian population | Number | Percent of civilian population |
| 1950 | 55, 950 | 17, 253 | 1, 151 | 16, 102 | 34, 937 | 21, 219 | 13, 718 | 3, 760 | 940 | 1, 950 | 600 | 270 | ---- | ---- | ---- | ---- |
| 1955 | 98, 000 | 37, 395 | 3, 194 | 34, 201 | 54, 675 | 39, 703 | 14, 972 | 5, 930 | 2, 130 | 3, 200 | 430 | 170 | ---- | ---- | ---- | ---- |
| 1960 | 127, 091 | 48, 266 | 3, 773 | 44, 493 | 71, 489 | 55, 464 | 16, 025 | 7, 336 | 2, 760 | 4, 020 | 346 | 210 | ---- | ---- | ---- | ---- |
| 1965 | 148, 236 | 56, 330 | 3, 660 | 52, 669 | 83, 222 | 65, 487 | 17, 735 | 8, 684 | 3, 400 | 5, 068 | 10 | 206 | ---- | ---- | 130, 530 | 67. 7 |
| 1966 | 152, 106 | 57, 916 | 3, 417 | 54, 499 | 85, 865 | 68, 114 | 17, 751 | 8, 325 | 3, 526 | 4, 601 | ---- | 198 | ---- | ---- | 133, 995 | 68. 9 |
| 1967 | 158, 654 | 60, 433 | 3, 416 | 57, 017 | 89, 641 | 72, 038 | 17, 603 | 8, 580 | 3, 900 | 4, 500 | ---- | 180 | 142, 082 | 72. 2 | 138, 898 | 70. 6 |
| 1968 | 164, 540 | 63, 279 | 3, 464 | 59, 815 | 92, 509 | 75, 038 | 17, 471 | 8, 752 | 4, 132 | 4, 476 | ---- | 143 | 148, 082 | 74. 5 | 143, 625 | 72. 2 |
| 1969 | 173, 108 | 66, 595 | 3, 629 | 62, 966 | 96, 563 | 78, 864 | 17, 699 | 9, 950 | 4, 500 | 5, 300 | ---- | 150 | ---- | ---- | 147, 774 | 73. 6 |
| 1970 | 179, 152 | 69, 110 | 3, 874 | 65, 236 | 99, 510 | 81, 549 | 17, 961 | 10, 532 | 4, 900 | 5, 500 | ---- | 132 | 150, 001 | 73. 9 | 151, 440 | 74. 6 |
| 1971 | 181, 191 | 70, 395 | 3, 831 | 66, 564 | 99, 936 | 81, 802 | 18, 134 | 10, 860 | 5, 100 | 5, 630 | ---- | 130 | ---- | ---- | 153, 093 | 74. 5 |
| 1972 | 185, 153 | 72, 433 | 4, 020 | 68, 413 | 101, 230 | 82, 670 | 18, 560 | 11, 490 | 5, 350 | 6, 000 | ---- | 140 | 152, 651 | 73. 6 | 154, 687 | 74. 6 |
| 1973 | 190, 359 | 75, 136 | 4, 098 | 71, 038 | 103, 091 | 84, 483 | 18, 608 | 12, 132 | 5, 930 | 6, 057 | ---- | 145 | ---- | ---- | 158, 624 | 75. 9 |
| 1974 | 194, 576 | 76, 873 | 4, 239 | 72, 634 | 105, 164 | 86, 630 | 18, 534 | 12, 539 | 6, 110 | 6, 275 | ---- | 154 | 159, 518 | 75. 7 | 162, 571 | 77. 2 |

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[1] Estimated by applying percentages to total civilian population.

TABLE 8.—*Hospital benefits: Gross enrollment under private health insurance plans and estimates of the net number of different persons covered, by age and type of plan, 1960–72*

[In thousands]

| End of year | Gross enrollments | | | | | Net number of different persons covered, as estimated by— | | | | Gross enrollment as percent of net, estimated by— | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Insurance companies | | | Household surveys | | HIAA | | | |
| | Total | Blue Cross-Blue Shield | Group policies | Individual policies | Independent plans | Number | Percent of civilian population | Number | Percent of civilian population | Household surveys | HIAA |
| | | | | | Under age 65 | | | | | | |
| 1960 | 139, 855 | 53, 070 | 53, 718 | 27, 487 | 5, 580 | | | 120, 772 | 74. 1 | | 115. 8 |
| 1961 | 142, 576 | 52, 750 | 55, 263 | 27, 951 | 6, 612 | | | 124, 595 | 75. 4 | | 114. 4 |
| 1962 | 146, 626 | 54, 194 | 56, 853 | 29, 121 | 6, 458 | 120, 220 | 72. 3 | 128, 877 | 76. 8 | 122. 0 | 114. 0 |
| 1963 | 152, 822 | 55, 072 | 60, 417 | 30, 662 | 6, 671 | | | 133, 267 | 78. 2 | | 114. 7 |
| 1964 | 157, 083 | 56, 663 | 62, 006 | 32, 057 | 6, 357 | | | (1) | (1) | | |
| 1965 | 162, 461 | 57, 884 | 64, 504 | 33, 572 | 6, 501 | | | 140, 219 | 80. 3 | | 115. 9 |
| 1966 | 170, 053 | 60, 575 | 67, 546 | 35, 729 | 6, 203 | | | 146, 507 | 83. 3 | | 116. 1 |
| 1967 | 175, 672 | 62, 103 | 71, 279 | 35, 670 | 6, 620 | 136, 907 | 77. 0 | 151, 628 | 85. 3 | 128. 3 | 115. 9 |
| 1968 | 182, 440 | 65, 086 | 74, 128 | 36, 451 | 6, 775 | 141, 572 | 78. 9 | 157, 128 | 87. 6 | 128. 9 | 116. 1 |
| 1969 | 190, 320 | 67, 251 | 78, 194 | 37, 621 | 7, 254 | | | 160, 189 | 88. 3 | | 118. 8 |
| 1970 | 197, 038 | 69, 128 | 80, 685 | 39, 595 | 7, 630 | 143, 611 | 78. 6 | 164, 210 | 89. 9 | 137. 2 | 120. 0 |
| 1971 | 201, 365 | 69, 704 | 81, 047 | 42, 589 | 8, 025 | [2] 146, 565 | 79. 4 | 167, 588 | 90. 7 | 137. 4 | 120. 2 |
| 1972 | 207, 451 | 71, 677 | 82, 261 | 45, 073 | 8, 440 | [3] 148, 285 | 79. 7 | 169, 555 | 91. 1 | 140. 0 | 122. 4 |
| | | | | | Aged 65 and over | | | | | | |
| 1960 | 9, 008 | 4, 394 | 1, 500 | 2, 700 | 414 | | | 9, 235 | 54. 8 | | 97. 5 |
| 1961 | 10, 450 | 5, 210 | 1, 750 | 3, 000 | 490 | | | 9, 822 | 57. 2 | | 106. 4 |
| 1962 | 12, 003 | 5, 424 | 2, 300 | 3, 800 | 479 | 9, 125 | 54. 1 | 10, 299 | 59. 1 | 131. 5 | 116. 5 |
| 1963 | 12, 320 | 5, 626 | 2, 400 | 3, 800 | 494 | | | 11, 308 | 63. 8 | | 108. 9 |
| 1964 | 12, 538 | 5, 766 | 2, 500 | 3, 800 | 472 | | | (1) | (1) | | |
| 1965 | 12, 661 | 5, 778 | 2, 600 | 3, 800 | 483 | | | 11, 264 | 61. 5 | | 112. 4 |
| 1966 | 10, 439 | 5, 073 | 2, 024 | 2, 912 | 430 | | | 9, 357 | 50. 1 | | 111. 6 |
| 1967 | 10, 150 | 5, 410 | 2, 072 | 2, 238 | 430 | 8, 547 | 45. 0 | 9, 021 | 47. 5 | 118. 8 | 112. 5 |
| 1968 | 11, 115 | 5, 424 | 1, 931 | 3, 258 | 502 | [4] 9, 316 | 48. 2 | 10, 081 | 52. 2 | 119. 3 | 110. 3 |
| 1969 | 12, 155 | 5, 960 | 1, 899 | 3, 848 | 448 | | | 10, 666 | 54. 3 | | 114. 0 |
| 1970 | 12, 749 | 6, 336 | 2, 027 | 3, 885 | 501 | 10, 452 | 51. 4 | 11, 172 | 54. 9 | 122. 0 | 114. 1 |
| 1971 | 12, 909 | 6, 645 | 1, 806 | 3, 938 | 520 | [5] 10, 618 | 51. 1 | 11, 350 | 54. 6 | 121. 6 | 113. 7 |
| 1972 | 13, 821 | 6, 928 | 1, 507 | 4, 836 | 550 | [5] 11, 270 | [6] 53. 2 | 12, 047 | 56. 9 | 122. 6 | 114. 7 |

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[1] Data not available.

[2] Estimated by applying HIAA percentage increase in net enrollment from 1970 to 1971 to the NCHS figures for 1970.

[3] Estimated by applying HIAA percentage increase in net enrollment from 1971 to 1972 to the 1971 estimate.

[4] Estimated on basis of percentage increase in gross enrollment from the preceding year.

[5] Estimated on basis of HIAA percentage increase in net enrollment from the preceding year.

[6] In the Current Medicare Survey of the Social Security Administration, 57.6 percent of those enrolled for supplementary medical insurance were reported as having private hospital insurance as of Jan. 1, 1973.

TABLE 9.—*Surgical benefits: Gross enrollment under private health insurance plans and estimates of the net number of different persons covered, by age and type of plan, 1960–74*

[In thousands]

| End of year | Gross enrollments |  |  |  |  | Net number of different persons covered, as estimated by— |  |  |  | Gross enrollment as percent of net, estimated by— |  |
|---|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  | Insurance companies |  |  | Household surveys |  | HIAA |  |  |  |
|  | Total | Blue Cross-Blue Shield | Group policies | Individual policies | Independent plans | Number | Percent of civilian population | Number | Percent of civilian population | Household surveys | HIAA |
|  | Under age 65 |  |  |  |  |  |  |  |  |  |  |
| 1960 | 127, 386 | 45, 226 | 54, 104 | 21, 212 | 6, 844 |  |  | 109, 452 | 67. 2 |  | 116. 4 |
| 1961 | 132, 209 | 45, 649 | 55, 673 | 22, 962 | 7, 925 |  |  | 114, 645 | 69. 3 |  | 115. 3 |
| 1962 | 134, 609 | 46, 599 | 57, 487 | 22, 791 | 7, 732 | 113, 569 | 68. 3 | (¹) | (¹) | 118. 5 |  |
| 1963 | 139, 278 | 46, 086 | 60, 888 | 24, 273 | 8, 031 |  |  | 122, 112 | 71. 6 |  | 114. 1 |
| 1964 | 144, 811 | 49, 825 | 62, 439 | 24, 806 | 7, 741 |  |  | (¹) | (¹) |  |  |
| 1965 | 150, 946 | 51, 348 | 64, 957 | 26, 539 | 8, 102 |  |  | 129, 514 | 74. 2 |  | 116. 5 |
| 1966 | 157, 504 | 53, 613 | 68, 574 | 27, 479 | 7, 838 |  |  | 136, 062 | 77. 4 |  | 115. 8 |
| 1967 | 163, 643 | 56, 020 | 72, 583 | 26, 965 | 8, 075 | 133, 706 | 75. 2 | 141, 208 | 79. 4 | 122. 4 | 115. 9 |
| 1968 | 168, 588 | 58, 390 | 75, 619 | 26, 300 | 8, 279 | 139, 061 | 77. 5 | 145, 553 | 81. 1 | 121. 2 | 115. 8 |
| 1969 | 176, 716 | 60, 499 | 79, 571 | 27, 196 | 9, 450 |  |  | 149, 847 | 82. 6 |  | 117. 9 |
| 1970 | 183, 587 | 63, 066 | 82, 201 | 28, 347 | 9, 973 | 140, 505 | 76. 9 | 153, 352 | 83. 9 | 130. 7 | 119. 7 |
| 1971 | 185, 865 | 63, 891 | 82, 548 | 29, 144 | 10, 282 | [2] 141, 944 | 76. 9 | 154, 923 | 83. 9 | 130. 9 | 120. 0 |
| 1972 | 191, 023 | 65, 642 | 83, 786 | 30, 725 | 10, 870 | [3] 143, 523 | 77. 1 | 156, 646 | 84. 2 | 133. 1 | 122. 0 |
| 1973 | 196, 110 | 67, 798 | 82, 861 | 33, 989 | 11, 462 | 145, 352 | 77. 6 | 159, 462 | 85. 1 |  | 123. 0 |
| 1974 | 182, 960 | 69, 838 | 85, 170 | 16, 118 | 11, 834 | 147, 570 | 78. 3 | 153, 346 | 81. 4 |  |  |
|  | Aged 65 and over |  |  |  |  |  |  |  |  |  |  |
| 1960 | 6, 732 | 3, 040 | 1, 400 | 1, 800 | 492 |  |  | 7, 852 | 46. 6 |  | 85. 7 |
| 1961 | 7, 894 | 3, 725 | 1, 700 | 1, 900 | 569 |  |  | 8, 306 | 48. 4 |  | 95. 0 |
| 1962 | 9, 832 | 4, 277 | 2, 300 | 2, 700 | 555 | 7, 792 | 46. 2 | (¹) | (¹) | 126. 2 | (¹) |
| 1963 | 9, 962 | 4, 285 | 2, 400 | 2, 700 | 577 |  |  | 9, 842 | 55. 6 |  | 101. 2 |
| 1964 | 10, 404 | 4, 648 | 2, 500 | 2, 700 | 556 |  |  | (¹) | (¹) |  | (¹) |
| 1965 | 10, 864 | 4, 982 | 2, 600 | 2, 700 | 582 |  |  | 9, 923 | 54. 2 |  | 109. 5 |
| 1966 | 8, 307 | 4, 304 | 1, 694 | 1, 822 | 487 |  |  | 7, 222 | 38. 7 |  | 115. 0 |
| 1967 | 8, 407 | 4, 413 | 1, 735 | 1, 754 | 505 | 8, 376 | 44. 1 | 7, 521 | 39. 6 | 100. 4 | 111. 8 |
| 1968 | 9, 059 | 4, 889 | 1, 796 | 1, 901 | 473 | [4] 9, 021 | 46. 7 | 8, 424 | 43. 6 | 100. 4 | 107. 5 |
| 1969 | 10, 289 | 6, 096 | 1, 792 | 1, 901 | 500 |  |  | 8, 737 | 44. 5 |  | 117. 8 |
| 1970 | 10, 316 | 6, 044 | 1, 932 | 1, 781 | 559 | 9, 496 | 46. 7 | 9, 303 | 45. 8 | 108. 6 | 110. 9 |
| 1971 | 10, 594 | 6, 504 | 1, 846 | 1, 666 | 578 | [5] 9, 766 | 47. 0 | 9, 568 | 46. 0 | 108. 5 | 110. 7 |
| 1972 | 10, 679 | 6, 791 | 1, 504 | 1, 764 | 620 | [5] 9, 813 | [6] 46. 3 | 9, 615 | 45. 4 | 108. 8 | 111. 1 |
| 1973 | 11, 014 | 7, 338 | 1, 165 | 1, 841 | 670 | 11, 561 | 53. 6 | 9, 954 | 46. 1 |  | 110. 6 |
| 1974 | 11, 616 | 7, 035 | 1, 460 | 2, 416 | 705 | 11, 948 | 54. 0 | 9, 225 | 41. 7 |  |  |

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[1] Data not available.

[2] See footnote 2, table 8.

[3] See footnote 3, table 8.

[4] See footnote 4, table 8.

[5] See footnote 5, table 8.

[6] In the Current Medicare Survey of the Social Security Administration, 46.7 percent of those enrolled for supplementary medical insurance were reported as having private surgical insurance as of Jan. 1, 1973.

TABLE 10.—*Estimates of the net number of different persons under private health insurance plans and percent of population covered by specified type of care, 1962–74*

| End of year | Hospital care | Physicians' services | | | | Dental care | Prescribed drugs (out-of-hospital) | Private-duty nursing | Visiting-nurse service | Nursing-home care |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Surgical services | In-hospital visits | X-ray and laboratory examinations | Office and home visits | | | | | |
| Number (in thousands): | | | | | | | | | | |
| 1962 | 129, 800. 0 | 120, 528. 0 | (1) | 65, 671. 0 | (1) | 1, 006. 0 | 47, 907. 0 | 46, 143. 0 | 43, 203. 0 | 4, 975. 0 |
| 1965 | (1) | (1) | (1) | 79, 500. 0 | (1) | 3, 100. 0 | 53, 200. 0 | 56, 000. 0 | 60, 100. 0 | 9, 900. 0 |
| 1966 | (1) | (1) | (1) | 90, 000. 0 | (1) | 4, 227. 0 | 65, 544. 0 | 68, 722. 0 | 79, 004. 0 | 17, 814. 0 |
| 1967 | 145, 454. 0 | 142, 082. 0 | (1) | 92, 480. 0 | (1) | 4, 679. 0 | 71, 201. 0 | 76, 080. 0 | 81, 771. 0 | 18, 754. 0 |
| 1968 | (1) | (1) | 128, 174. 0 | 97, 703. 0 | (1) | 5, 821. 0 | 79, 280. 0 | 83, 485. 0 | 90, 523. 0 | 19, 046. 0 |
| 1969 | (1) | (1) | 133, 914. 0 | 125, 002. 0 | (1) | 8, 510. 0 | 89, 805. 0 | 91, 211. 0 | 100, 343. 0 | 28, 044. 0 |
| 1970 | 154, 263. 0 | 150, 001. 0 | 145, 589. 0 | 142, 441. 0 | 101, 970. 0 | 12, 210. 0 | 100, 966. 0 | 100, 235. 0 | 106, 882. 0 | 32, 392. 0 |
| 1971 | (1) | (1) | 148, 514. 0 | 145, 207. 0 | (1) | 15, 348. 0 | 106, 985. 0 | 104, 730. 0 | 110, 215. 0 | 38, 636. 0 |
| 1972 | 155, 253. 0 | 152, 651. 0 | 149, 734. 0 | 149, 444. 0 | (1) | 17, 904. 0 | 111, 374. 0 | 108, 959. 0 | 115, 904. 0 | 45, 460. 0 |
| 1973 | (1) | (1) | 153, 461. 0 | 152, 797. 0 | (1) | 21, 626. 0 | 124, 971. 0 | 118, 805. 0 | 122, 688. 0 | 69, 152. 0 |
| 1974 | 163, 396. 0 | 159, 518. 0 | 155, 022. 0 | 153, 017. 0 | 125, 183. 0 | 33, 297. 0 | 141, 755. 0 | 141, 167. 0 | 136, 687. 0 | 69, 840. 0 |
| Percent of civilian population: | | | | | | | | | | |
| 1962 | 70. 0 | 65. 0 | (1) | 35. 0 | (1) | . 5 | 26. 0 | 25. 0 | 23. 0 | 3. 0 |
| 1965 | (1) | (1) | (1) | 41. 2 | (1) | 1. 6 | 27. 6 | 29. 0 | 31. 2 | 5. 1 |
| 1966 | (1) | (1) | (1) | 48. 0 | (1) | 2. 2 | 33. 7 | 35. 0 | 40. 6 | 9. 2 |
| 1967 | 73. 9 | 72. 2 | (1) | 47. 0 | (1) | 2. 4 | 36. 2 | 38. 7 | 41. 6 | 9. 2 |
| 1968 | (1) | (1) | 64. 5 | 49. 2 | (1) | 2. 9 | 39. 9 | 42. 0 | 45. 5 | 9. 6 |
| 1969 | (1) | (1) | 66. 6 | 62. 2 | (1) | 4. 2 | 44. 7 | 45. 4 | 49. 9 | 14. 0 |
| 1970 | 75. 9 | 73. 9 | 71. 7 | 70. 2 | 50. 2 | 6. 0 | 49. 7 | 49. 4 | 52. 6 | 16. 0 |
| 1971 | (1) | (1) | 72. 3 | 70. 7 | (1) | 7. 5 | 52. 1 | 51. 0 | 53. 6 | 18. 8 |
| 1972 | 74. 9 | 73. 6 | 72. 2 | 72. 1 | (1) | 8. 6 | 53. 7 | 52. 6 | 55. 9 | 21. 9 |
| 1973 | (1) | (1) | 73. 4 | 73. 1 | (1) | 10. 4 | 59. 8 | 56. 9 | 58. 7 | 33. 1 |
| 1974 | 77. 6 | 75. 7 | 73. 6 | 72. 7 | 59. 4 | 15. 8 | 67. 3 | 67. 0 | 64. 9 | 33. 2 |

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[1] Data not available.

TABLE 11.—*Number of persons covered under major medical policies of insurance companies and under supplementary major-medical and comprehensive extended-benefit contracts of Blue Cross, Blue-Shield plans, 1960–74*

[In thousands]

| End of year | Insurance companies | | | | | Blue Cross-Blue Shield [1] | | |
|---|---|---|---|---|---|---|---|---|
| | | Group policies | | | | | | |
| | Total | Net total | Supplementary | Comprehensive | Individual policies | Total | Supplementary major-medical | Comprehensive extended-benefit |
| 1960 | 25, 371 | 24, 429 | 17, 991 | 8, 463 | 1, 607 | 3, 713 | 3, 020 | 693 |
| 1961 | 32, 334 | 30, 729 | 24, 488 | 9, 851 | 2, 372 | 5, 059 | 4, 015 | 1, 044 |
| 1962 | 37, 130 | 35, 002 | 28, 445 | 10, 636 | 2, 949 | 7, 501 | 5, 068 | 1, 735 |
| 1963 | 42, 003 | 39, 446 | 32, 307 | 11, 699 | 3, 459 | (2) | (2) | (2) |
| 1964 | 47, 338 | 44, 087 | 36, 925 | 12, 241 | 4, 185 | (2) | (2) | (2) |
| 1965 | 53, 020 | 49, 700 | 42, 450 | 12, 962 | 4, 456 | [3] 14, 600 | (2) | (2) |
| 1966 | 57, 881 | 54, 732 | 46, 830 | 14, 154 | 4, 516 | 14, 352 | 10, 409 | 3, 943 |
| 1967 | 63, 248 | 60, 517 | 51, 824 | 15, 570 | 4, 552 | 16, 279 | 12, 408 | 3, 871 |
| 1968 | 68, 171 | 65, 076 | 55, 422 | 17, 014 | 4, 873 | 17, 807 | 14, 078 | 3, 729 |
| 1969 | 73, 752 | 70, 272 | 58, 905 | 19, 260 | 5, 377 | 20, 328 | 16, 666 | 3, 662 |
| 1970 | 77, 061 | 73, 702 | 61, 718 | 20, 244 | 5, 414 | 24, 905 | 21, 658 | 3, 247 |
| 1971 | 80, 252 | 76, 971 | 63, 442 | 22, 111 | 5, 479 | 26, 780 | 23, 429 | 3, 351 |
| 1972 | 83, 668 | 79, 025 | 64, 443 | 23, 363 | 6, 630 | 30, 082 | 26, 879 | 3, 203 |
| 1973 | 87, 839 | 82, 724 | 66, 225 | 25, 690 | 7, 310 | 37, 328 | 33, 947 | 3, 381 |
| 1974 | 91, 321 | 86, 256 | 68, 122 | 27, 718 | 7, 235 | 40, 862 | 37, 239 | 3, 623 |

[1] Comparable data not available for earlier years; before 1965 data shown are for Blue Cross plans only; beginning 1965, data are jointly developed by Blue Cross Association and National Association of Blue Shield Plans on unduplicated number of persons covered.

[2] Data not available.

[3] Data for Blue Cross plans plus an estimated 1,600,000 in Blue Shield plans not affiliated with Blue Cross.

TABLE 12.—*Private health insurance enrollment under independent group practice prepayment plans, by specified type of care, 1953–74*

[In thousands]

| Year | Hospital care | Physicians' services | | | Dental care | Drugs |
|---|---|---|---|---|---|---|
| | | Surgical services | In-hospital visits | Office, clinic, or health center | | |
| 1953 | 1, 802 | 2, 410 | 2, 507 | 2, 853 | 452 | (1) |
| 1956 | 2, 428 | 3, 177 | 3, 399 | 3, 395 | 248 | (1) |
| 1959 | 2, 526 | 3, 280 | 3, 400 | 3, 694 | 318 | (1) |
| 1961 | 2, 586 | 3, 484 | 3, 643 | 3, 613 | 398 | 518 |
| 1964 | 2, 695 | 3, 504 | 3, 176 | 3, 844 | 438 | 889 |
| 1966 | 2, 771 | 3, 763 | 3, 430 | 4, 158 | (1) | (1) |
| 1967 | 3, 060 | 4, 130 | 3, 760 | 4, 480 | (1) | (1) |
| 1968 | 3, 043 | 4, 051 | 3, 730 | 4, 404 | 518 | 1, 382 |
| 1969 | 3, 730 | 4, 750 | 4, 210 | 5, 050 | 800 | 1, 720 |
| 1970 | 4, 131 | 5, 032 | 4, 532 | 5, 432 | 910 | 2, 121 |
| 1971 | 4, 415 | 5, 230 | 4, 880 | 5, 630 | 965 | 2, 321 |
| 1972 | 4, 679 | 5, 473 | 5, 123 | 5, 865 | 977 | 2, 543 |
| 1973 | 4, 905 | 5, 671 | 5, 288 | 6, 066 | 1, 000 | [2] 1, 741 |
| 1974 | 4, 976 | 5, 779 | 5, 424 | 6, 174 | 997 | [2] 1, 821 |

[1] Data not available.

[2] Excludes those enrolled under plans that sell drugs to members at reduced rates.

TABLE 13.—*Financial experience of private health insurance organizations, 1974*

[Amounts in millions]

| Type of plan | Total income | Subscription or premium income | Claims expense | | Operating expense | | Net underwriting gain | | Net income | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Amount | Percent of premium income | Amount | Percent of premium income | Amount | Percent of premium income | Amount | Percent of total income |
| Total | (¹) | $28, 399. 9 | $24, 766. 8 | 87. 2 | $3, 992. 8 | 14. 1 | $359. 7 | −1. 3 | (¹) | (¹) |
| Blue Cross-Blue Shield | $12, 611. 8 | 12, 367. 0 | 11, 639. 5 | 94. 1 | 911. 0 | 7. 4 | −183. 5 | −1. 5 | $61. 3 | 0. 5 |
| Blue Cross | 8, 757. 7 | 8, 647. 6 | 8, 311. 1 | 96. 1 | 470. 2 | 5. 4 | −133. 7 | −1. 5 | −23. 6 | −. 3 |
| Blue Shield | 3, 854. 1 | 3, 719. 4 | 3, 328. 4 | 89. 5 | 440. 8 | 11. 8 | −49. 8 | −1. 3 | 84. 9 | 2. 2 |
| Insurance companies | (¹) | 13, 867. 0 | 11, 109. 3 | 80. 1 | 2, 916. 9 | 21. 0 | −159. 2 | −1. 1 | (¹) | (¹) |
| Group policies | (¹) | 10, 590. 0 | 9, 592. 2 | 90. 6 | 1, 376. 7 | 13. 0 | −378. 9 | −3. 6 | (¹) | (¹) |
| Individual policies | (¹) | 3, 277. 0 | 1, 517. 1 | 46. 3 | 1, 540. 2 | 47. 0 | 219. 7 | 6. 7 | (¹) | (¹) |
| Independent plans | 2, 221. 0 | 2, 165. 9 | 2, 018. 0 | 93. 2 | 164. 9 | 7. 6 | −17. 0 | −. 8 | 38. 1 | 1. 7 |
| Community | 855. 4 | 847. 5 | 798. 1 | 94. 2 | 57. 2 | 6. 7 | −7. 8 | −. 9 | . 1 | (¹) |
| Employer-employee-union | 938. 0 | 897. 0 | 853. 4 | 95. 1 | 62. 7 | 7. 0 | −19. 1 | −2. 1 | 21. 9 | 2. 3 |
| Private group clinic | 34. 8 | 33. 4 | 26. 5 | 79. 3 | 5. 0 | 15. 0 | 1. 9 | 5. 7 | 3. 3 | 9. 5 |
| Dental service corporation | 392. 8 | 388. 0 | 340. 0 | 87. 6 | 40. 0 | 10. 3 | 8. 0 | 2. 1 | 12. 8 | 3. 3 |

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[1] Data not available.
[2] Less than 0.05 percent.

TABLE 14.—*Percentage distribution of subscription or premium income and claims expense, by type of private health insurance organization, 1948–73*

| Year | Total | Blue Cross-Blue Shield plans |  |  | Insurance companies |  |  | Independent plans |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  |  | Total | Blue Cross | Blue Shield | Total | Group policies | Individual policies | Total | Community | Employer-employee-union | Private group clinic | Dental service corporation |
|  |  | Subscription or premium income |  |  |  |  |  |  |  |  |  |  |
| 1948 | 100.0 | 42.3 | 36.5 | 5.8 | 48.8 | 24.6 | 24.2 | 8.8 | (1) | (1) | (1) | (1) |
| 1950 | 100.0 | 44.4 | 33.8 | 10.6 | 46.8 | 25.8 | 21.1 | 8.7 | (1) | (1) | (1) | (1) |
| 1955 | 100.0 | 41.0 | 28.9 | 12.1 | 51.7 | 32.5 | 19.2 | 7.3 | (1) | (1) | (1) | (1) |
| 1960 | 100.0 | 42.5 | 30.4 | 12.1 | 51.8 | 36.0 | 15.8 | 5.7 | 2.3 | 3.2 | 0.2 | (2) |
| 1961 | 100.0 | 42.0 | 30.0 | 12.0 | 51.4 | 36.2 | 15.2 | 6.6 | 2.2 | 3.8 | .2 | 0.1 |
| 1962 | 100.0 | 42.1 | 29.9 | 12.2 | 51.4 | 36.5 | 14.9 | 6.5 | 2.2 | 3.8 | .1 | (2) |
| 1963 | 100.0 | 42.2 | 30.3 | 11.9 | 51.4 | 36.2 | 15.2 | 6.4 | 2.3 | 3.6 | .2 | .1 |
| 1964 | 100.0 | 42.1 | 30.0 | 12.1 | 51.8 | 36.7 | 15.1 | 6.1 | 2.2 | 3.7 | .1 | .1 |
| 1965 | 100.0 | 41.7 | 29.9 | 11.8 | 52.2 | 36.6 | 15.6 | 6.1 | 2.2 | 3.7 | .1 | .1 |
| 1966 | 100.0 | 41.0 | 29.2 | 11.8 | 52.9 | 37.7 | 15.2 | 6.1 | 2.3 | 3.5 | .1 | .2 |
| 1967 | 100.0 | 41.0 | 29.1 | 11.9 | 52.8 | 38.5 | 14.3 | 6.2 | 2.5 | 3.3 | .1 | .3 |
| 1968 | 100.0 | 40.2 | 28.4 | 11.8 | 53.7 | 40.0 | 13.7 | 6.1 | 2.5 | 3.2 | .1 | .3 |
| 1969 | 100.0 | 42.0 | 29.8 | 12.2 | 51.6 | 38.8 | 12.8 | 6.4 | 2.6 | 3.3 | .1 | .4 |
| 1970 | 100.0 | 42.9 | 30.0 | 12.9 | 50.9 | 39.4 | 11.5 | 6.2 | 2.6 | 3.1 | .1 | .4 |
| 1971 | 100.0 | 44.7 | 31.7 | 13.0 | 48.8 | 36.8 | 12.0 | 6.5 | 2.7 | 3.3 | .1 | .4 |
| 1972 | 100.0 | 44.4 | 31.6 | 12.8 | 48.8 | 37.2 | 11.6 | 6.8 | 2.8 | 3.2 | .1 | .7 |
| 1973 | 100.0 | 45.1 | 32.1 | 13.0 | 47.7 | 36.6 | 11.1 | 7.2 | 2.9 | 3.3 | .1 | .9 |
|  |  | Claims expense |  |  |  |  |  |  |  |  |  |  |
| 1948 | 100.0 | 50.8 | 44.4 | 6.4 | 37.6 | 24.4 | 13.2 | 11.6 | (1) | (1) | (1) | (1) |
| 1950 | 100.0 | 49.5 | 38.6 | 10.9 | 40.3 | 25.9 | 14.4 | 10.2 | (1) | (1) | (1) | (1) |
| 1955 | 100.0 | 45.2 | 32.8 | 12.4 | 46.5 | 33.8 | 12.7 | 8.3 | (1) | (1) | (1) | (1) |
| 1960 | 100.0 | 45.8 | 32.9 | 12.8 | 47.8 | 38.0 | 9.8 | 6.4 | (1) | (1) | (1) | (1) |
| 1961 | 100.0 | 45.4 | 32.8 | 12.6 | 47.5 | 38.1 | 9.4 | 7.1 | (1) | (1) | (1) | (1) |
| 1962 | 100.0 | 45.6 | 32.5 | 13.1 | 47.5 | 38.7 | 8.8 | 6.9 | (1) | (1) | (1) | (1) |
| 1963 | 100.0 | 45.6 | 33.2 | 12.4 | 47.7 | 38.3 | 9.5 | 6.7 | (1) | (1) | (1) | (1) |
| 1964 | 100.0 | 45.6 | 33.1 | 12.5 | 48.0 | 38.6 | 9.4 | 6.3 | (1) | (1) | (1) | (1) |
| 1965 | 100.0 | 44.8 | 32.7 | 12.1 | 48.9 | 39.1 | 9.8 | 6.3 | 2.3 | 3.8 | .1 | .1 |
| 1966 | 100.0 | 43.5 | 31.5 | 12.0 | 50.2 | 40.6 | 9.6 | 6.4 | 2.4 | 3.6 | .1 | .2 |
| 1967 | 100.0 | 42.8 | 31.0 | 11.7 | 50.7 | 41.9 | 8.8 | 6.5 | 2.6 | 3.5 | .1 | .3 |
| 1968 | 100.0 | 42.7 | 31.1 | 11.6 | 51.0 | 42.7 | 8.3 | 6.3 | 2.6 | 3.3 | .1 | .3 |
| 1969 | 100.0 | 45.2 | 32.7 | 12.5 | 48.2 | 40.9 | 7.3 | 6.6 | 2.7 | 3.4 | .1 | .4 |
| 1970 | 100.0 | 44.9 | 31.9 | 13.0 | 48.6 | 41.3 | 7.3 | 6.5 | 2.7 | 3.4 | .1 | .3 |
| 1971 | 100.0 | 46.2 | 33.4 | 12.8 | 47.1 | 39.9 | 7.2 | 6.7 | 2.9 | 3.4 | .1 | .3 |
| 1972 | 100.0 | 46.1 | 33.3 | 12.8 | 46.7 | 39.7 | 7.0 | 7.2 | 2.9 | 3.5 | .1 | .7 |
| 1973 | 100.0 | 46.3 | 33.3 | 13.0 | 45.9 | 38.5 | 7.4 | 7.8 | 3.2 | 3.6 | .1 | .9 |

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[1] Data not available.

[2] Less than 0.05 percent.

TABLE 15.—*Benefit expenditures of private health insurance organizations, by specified type of care, 1974*

[In millions]

| Type of plan | Total | Hospital care | Physicians' services | Dental care | Prescribed drugs (out-of hospital) | Private-duty nursing | Visiting-nurse service | Nursing-home care | Vision care | Other types of care |
|---|---|---|---|---|---|---|---|---|---|---|
| Total | $24, 766. 8 | $15, 005. 6 | $7, 795. 3 | $778. 4 | $619. 3 | $211. 6 | $8. 4 | $27. 9 | $13. 2 | $307. 1 |
| Blue Cross-Blue Shield | 11, 639. 5 | 7, 841. 3 | 3, 304. 0 | 53. 5 | 183. 3 | 14. 6 | 7. 0 | 25. 9 | 2. 8 | 207. 1 |
| Blue Cross | 8, 311. 1 | 7, 670. 0 | 322. 2 | 31. 5 | 89. 8 | 11. 1 | 6. 2 | 25. 2 | 1. 6 | 153. 5 |
| Blue Shield | 3, 328. 4 | 171. 3 | 2, 981. 8 | 22. 0 | 93. 5 | 3. 5 | 8 | . 7 | 1. 2 | 53. 6 |
| Insurance companies | 11. 109. 3 | 6, 458. 0 | 3, 705. 0 | 332. 2 | 344. 9 | 194. 1 | (1) | (1) | (1) | 75. 1 |
| Group policies | 9, 592. 2 | 5, 398. 6 | 3, 315. 1 | 332. 2 | 342. 6 | 129. 6 | (1) | (1) | (1) | 74. 1 |
| Individual policies | 1, 517. 1 | 1, 059. 4 | 389. 9 | --- | 2. 3 | 64. 5 | (1) | (1) | (1) | 1. 0 |
| Independent plans | 2, 018. 0 | 706. 3 | 786. 3 | 392. 7 | 91. 1 | 2. 9 | 1. 4 | 2. 0 | 10. 4 | 24. 9 |
| Community | 798. 1 | 242. 6 | 480. 9 | 28. 0 | 27. 0 | 1. 4 | . 1 | . 2 | 6. 0 | 11. 9 |
| Employer-employee-union | 853. 4 | 455. 7 | 291. 5 | 22. 4 | 63. 5 | 1. 4 | 1. 3 | . 8 | 4. 2 | 12. 5 |
| Private group clinic | 26. 5 | 8. 0 | 13. 9 | 2. 3 | . 6 | . 1 | --- | 1. 0 | . 2 | . 4 |
| Dental service corporation | 340. 0 | --- | --- | 340. 0 | --- | --- | --- | --- | --- | --- |

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[1] Included in "other types of care."

TABLE 16.—*Subscription or premium income and benefit expenditures of private health organizations, 1950–74*

[In millions]

| Year | Total | Blue Cross-Blue Shield | | | Insurance companies | | | Independent plans |
|---|---|---|---|---|---|---|---|---|
| | | Total | Blue Cross | Blue Shield | Total | Group policies | Individual policies | |
| Income: | | | | | | | | |
| 1950 | $1, 291. 5 | $574. 0 | $436. 7 | $137. 3 | $605. 0 | $333. 0 | $272. 0 | $112. 5 |
| 1955 | 3, 149. 6 | 1, 292. 4 | 910. 7 | 381. 7 | 1, 626. 9 | 1, 022. 5 | 604. 4 | 230. 3 |
| 1960 | 5, 841. 0 | 2, 482. 0 | 1, 773. 0 | 709. 1 | 3, 027. 0 | 2, 104. 0 | 923. 0 | 331. 9 |
| 1965 | 10, 001. 3 | 4, 169. 0 | 2, 993. 7 | 1, 175. 3 | 5, 224. 0 | 3, 665. 0 | 1, 559. 0 | 608. 3 |
| 1966 | 10, 564. 1 | 4, 327. 8 | 3, 085. 9 | 1, 241. 9 | 5, 595. 0 | 3, 987. 0 | 1, 608. 0 | 641. 3 |
| 1967 | 11, 105. 3 | 4, 555. 3 | 3, 230. 0 | 1, 325. 3 | 5, 858. 0 | 4, 270. 0 | 1, 588. 0 | 692. 0 |
| 1968 | 12, 898. 7 | 5, 187. 1 | 3, 665. 0 | 1, 522. 1 | 6, 933. 0 | 5, 159. 0 | 1, 774. 0 | 778. 6 |
| 1969 | 14, 657. 7 | 6, 155. 6 | 4, 365. 2 | 1, 790. 4 | 7, 569. 0 | 5, 685. 0 | 1, 884. 0 | 933. 1 |
| 1970 | 17, 184. 8 | 7, 370. 9 | 5, 147. 1 | 2, 223. 8 | 8, 746. 0 | 6, 774. 0 | 1, 972. 0 | 1, 067. 9 |
| 1971 | 19, 659. 1 | 8, 790. 2 | 6, 239. 6 | 2, 550. 6 | 9, 601. 0 | 7, 231. 0 | 2, 370. 0 | 1, 267. 9 |
| 1972 | 22, 806. 8 | 9, 923. 3 | 7, 066. 9 | 2, 856. 4 | 11, 342. 0 | 8, 614. 0 | 2, 728. 0 | 1, 541. 5 |
| 1973 | 25, 294. 2 | 11, 059. 1 | 7, 862. 1 | 3, 197. 0 | 12, 386. 0 | 9, 393. 0 | 2, 993. 0 | 1, 849. 1 |
| 1974 | 28, 399. 9 | 12, 367. 0 | 8, 647. 6 | 3, 719. 4 | 13, 867. 0 | 10, 590. 0 | 3, 277. 0 | 2, 165. 9 |
| Benefit expenditures: | | | | | | | | |
| 1950 | $991. 9 | $490. 6 | $382. 9 | $107. 7 | $400. 0 | $257. 0 | $143. 0 | $101. 3 |
| 1955 | 2, 535. 7 | 1, 146. 7 | 832. 3 | 314. 5 | 1, 179. 0 | 858. 0 | 321. 0 | 210. 0 |
| 1960 | 4, 996. 3 | 2, 287. 1 | 1, 646. 2 | 640. 9 | 2, 389. 0 | 1, 901. 0 | 488. 0 | 320. 2 |
| 1965 | 8, 728. 9 | 3, 912. 9 | 2, 853. 4 | 1, 059. 5 | 4, 265. 0 | 3, 413. 0 | 852. 0 | 551. 0 |
| 1966 | 9, 141. 8 | 3, 975. 4 | 2, 882. 2 | 1, 093. 2 | 4, 585. 0 | 3, 711. 0 | 874. 0 | 581. 4 |
| 1967 | 9, 544. 8 | 4, 082. 8 | 2, 963. 1 | 1, 119. 7 | 4, 837. 0 | 3, 998. 0 | 839. 0 | 625. 0 |
| 1968 | 11, 343. 6 | 4, 840. 6 | 3, 529. 2 | 1, 311. 4 | 5, 791. 0 | 4, 841. 0 | 950. 0 | 712. 0 |
| 1969 | 13, 068. 5 | 5, 903. 1 | 4, 271. 4 | 1, 631. 7 | 6, 306. 0 | 5, 349. 0 | 957. 0 | 859. 4 |
| 1970 | 15, 743. 5 | 7, 060. 2 | 5, 009. 3 | 2, 050. 9 | 7, 656. 0 | 6, 510. 0 | 1, 146. 0 | 1, 027. 4 |
| 1971 | 17, 713. 1 | 8, 178. 7 | 5, 906. 9 | 2, 271. 8 | 8, 341. 0 | 7, 067. 0 | 1, 274. 0 | 1, 193. 4 |
| 1972 | 19, 532. 3 | 8, 990. 9 | 6, 501. 3 | 2, 489. 6 | 9, 120. 0 | 7, 754. 0 | 1, 366. 0 | 1, 421. 4 |
| 1973 | 21, 334. 7 | 10, 004. 2 | 7, 187. 3 | 2, 816. 9 | 9, 647. 7 | 8, 185. 3 | 1, 462. 4 | 1, 682. 8 |
| 1974 | 24, 766. 8 | 11, 639. 5 | 8, 311. 1 | 3, 328. 4 | 11, 109. 3 | 9, 592. 2 | 1, 517. 1 | 2, 018. 0 |

TABLE 17.—*Financial experience of Blue Cross plans, 1950–74* [1]

[Dollar amounts in thousands]

| Year | Reserves | Earned subscription income | Total earned income | Claims expense | Operating expense | Total net income | As percent of subscription income | | | Net income as percent of total income |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Claims expense | Operating expense | Underwriting gain | |
| 1950 | $116,531 | $433,770 | $436,984 | $383,331 | $36,281 | $17,371 | 88.4 | 8.4 | 3.3 | 4.0 |
| 1955 | 254,407 | 916,690 | 925,197 | 836,546 | 58,368 | 30,283 | 91.3 | 6.4 | 2.4 | 3.3 |
| 1960 | 363,253 | 1,783,172 | 1,802,789 | 1,654,951 | 90,821 | 57,017 | 92.8 | 5.1 | 2.1 | 3.2 |
| 1965 [2] | 561,906 | 3,031,470 | 3,074,551 | 2,887,187 | 134,559 | 52,805 | 95.2 | 4.5 | .3 | 1.7 |
| 1966 | 649,633 | 3,121,111 | 3,168,187 | 2,912,733 | 154,132 | 101,322 | 93.3 | 4.9 | 1.7 | 3.2 |
| 1967 | 797,575 | 3,270,022 | 3,327,677 | 2,996,779 | 177,632 | 153,266 | 91.6 | 5.4 | 3.0 | 4.6 |
| 1968 | 801,389 | 3,711,798 | 3,776,487 | 3,571,797 | 211,698 | −7,008 | 96.2 | 5.7 | −1.9 | −.2 |
| 1969 | 711,274 | 4,419,296 | 4,489,266 | 4,322,341 | 256,227 | −89,302 | 97.8 | 5.8 | −3.6 | −2.0 |
| 1970 | 651,655 | 5,385,835 | 5,467,512 | 5,220,662 | 302,463 | −55,613 | 96.9 | 5.6 | −2.5 | −1.0 |
| 1971 | 747,230 | 6,390,127 | 6,477,615 | 6,053,537 | 338,910 | 85,168 | 94.7 | 5.3 | (3) | 1.3 |
| 1972 | 1,053,428 | 7,280,243 | 7,386,914 | 6,681,619 | 385,029 | 320,266 | 91.8 | 5.3 | 2.9 | 4.3 |
| 1973 | 1,464,418 | 8,091,784 | 8,248,680 | 7,374,871 | 436,210 | 437,600 | 91.1 | 5.4 | 3.5 | 5.3 |
| 1974 | 1,606,507 | 8,736,512 | 8,932,360 | 8,283,503 | 505,798 | 143,059 | 94.8 | 5.8 | −.6 | 1.6 |

[1] Data in all years exclude Health Services, Inc., and Medical Indemnity of America, and are not adjusted for duplication between Blue Cross and Blue Shield.

[2] Includes Puerto Rico.

[3] Less than 0.05 percent.

TABLE 18.—*Financial experience of Blue Shield plans, 1950–74* [1]

[Dollar amounts in thousands]

| Year | Reserves | Earned subscription income | Total earned income | Claims expense | Operating expense | Total net income | As percent of subscription income | | | Net income as percent of total income |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Claims expense | Operating expense | Underwriting gain | |
| 1950 | $34,954 | $140,817 | $141,594 | $111,039 | $18,653 | $11,902 | 78.8 | 13.2 | 7.9 | 8.4 |
| 1955 | 164,705 | 399,781 | 404,294 | 331,068 | 43,610 | 29,616 | 82.8 | 10.9 | 6.3 | 7.3 |
| 1960 | 228,634 | 741,164 | 761,529 | 670,776 | 76,245 | 14,508 | 90.5 | 10.3 | −.8 | 1.9 |
| 1965 [2] | 347,266 | 1,318,915 | 1,338,907 | 1,190,486 | 115,940 | 32,481 | 90.3 | 8.8 | .9 | 2.4 |
| 1966 | 398,374 | 1,399,890 | 1,413,185 | 1,226,383 | 129,864 | 56,938 | 88.2 | 9.3 | 2.5 | 4.0 |
| 1967 | 509,094 | 1,489,640 | 1,519,309 | 1,261,650 | 148,750 | 108,909 | 84.7 | 10.0 | 5.3 | 7.2 |
| 1968 | 578,390 | 1,709,548 | 1,747,867 | 1,481,070 | 180,154 | 86,643 | 86.6 | 10.5 | 2.8 | 5.0 |
| 1969 | 555,079 | 2,007,970 | 2,054,571 | 1,834,495 | 222,519 | −2,438 | 91.4 | 11.1 | −2.5 | −.1 |
| 1970 | 491,066 | 2,320,877 | 2,369,600 | 2,165,572 | 254,726 | −50,698 | 93.3 | 11.0 | −4.3 | −2.1 |
| 1971 | 528,202 | 2,814,696 | 2,868,368 | 2,530,826 | 295,282 | 42,260 | 89.9 | 10.5 | −.4 | 1.5 |
| 1972 | 691,445 | 3,282,927 | 3,342,589 | 2,864,633 | 346,861 | 131,095 | 87.3 | 10.6 | 2.2 | 3.9 |
| 1973 | 791,147 | 3,761,845 | 3,841,613 | 3,339,650 | 396,965 | 104,998 | 88.8 | 10.6 | .7 | 2.7 |
| 1974 [3] | 802,957 | 5,197,629 | 5,285,098 | 4,827,006 | 523,635 | −65,513 | 92.9 | 10.1 | −2.9 | −1.2 |

[1] Data in all years exclude Health Services, Inc., and Medical Indemnity of American and are not adjusted for duplication between Blue Cross and Blue Shield.

[2] Includes Puerto Rico but excludes Jamaica.

[3] Data for 1974 are not directly comparable with earlier years because of the corporate merger of New York City Blue Cross and Blue Shield.

TABLE 19.—*Benefit expenditures of all private health insurance organizations, by specified type of care, 1950–74*

[Dollar amounts in millions]

| Year | Total | Hospital care | Physicians' services | Other types of care |
|---|---|---|---|---|
| Amount: | | | | |
| 1950 | $992 | $680 | $312 | (1) |
| 1955 | 2, 536 | 1, 679 | 857 | (1) |
| 1960 | 4, 996 | 3, 304 | 1, 593 | $99 |
| 1965 | 8, 729 | 5, 790 | 2, 680 | 259 |
| 1966 | 9, 142 | 5, 993 | 2, 831 | 318 |
| 1967 | 9, 545 | 6, 134 | 2, 964 | 447 |
| 1968 | 11, 344 | 7, 329 | 3, 477 | 538 |
| 1969 | 13, 069 | 8, 356 | 4, 029 | 684 |
| 1970 | 15, 744 | 10, 008 | 4, 908 | 828 |
| 1971 | 17, 713 | 11, 279 | 5, 430 | 1, 004 |
| 1972 | 19, 532 | 12, 242 | 6, 092 | 1, 198 |
| 1973 | 21, 335 | 13, 154 | 6, 683 | 1, 498 |
| 1974 | 24, 767 | 15, 006 | 7, 795 | 1, 966 |
| Percentage distribution: | | | | |
| 1950 | 100. 0 | 68. 5 | 31. 5 | (1) |
| 1955 | 100. 0 | 66. 2 | 33. 8 | (1) |
| 1960 | 100. 0 | 66. 1 | 31. 9 | 2. 0 |
| 1965 | 100. 0 | 66. 3 | 30. 7 | 3. 0 |
| 1966 | 100. 0 | 65. 5 | 31. 0 | 3. 5 |
| 1967 | 100. 0 | 64. 3 | 31. 0 | 4. 7 |
| 1968 | 100. 0 | 64. 6 | 30. 7 | 4. 7 |
| 1969 | 100. 0 | 63. 9 | 30. 8 | 5. 3 |
| 1970 | 100. 0 | 63. 6 | 31. 2 | 5. 2 |
| 1971 | 100. 0 | 63. 7 | 30. 6 | 5. 7 |
| 1972 | 100. 0 | 62. 7 | 31. 2 | 6. 1 |
| 1973 | 100. 0 | 61. 7 | 31. 3 | 7. 0 |
| 1974 | 100. 0 | 60. 6 | 31. 5 | 7. 9 |

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[1] Included in "physicians' services."

TABLE 20.—*Retentions*[1] *of private health insurance organizations as a percent of subscription or premium income, 1950–74*[2]

| Year | Total | Blue Cross-Blue Shield |  |  | Insurance companies |  |  | Independent plans[3] |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  |  | Total | Blue Cross | Blue Shield | Total | Group policies | Individual policies | Total | Community | Employer-employee union | Private group clinic | Dental service corporation |
| 1950 | 23. 2 | 14. 5 | 12. 3 | 21. 6 | 33. 9 | 22. 8 | 47. 4 | 10. 0 | (3) | (3) | (3) | (3) |
| 1955 | 19. 5 | 11. 3 | 8. 6 | 17. 6 | 27. 5 | 16. 1 | 46. 9 | 8. 8 | (3) | (3) | (3) | (3) |
| 1960 | 14. 5 | 7. 9 | 7. 2 | 9. 6 | 21. 1 | 9. 6 | 47. 1 | 3. 5 | (3) | (3) | (3) | (3) |
| 1965 | 12. 7 | 6. 1 | 4. 7 | 9. 9 | 18. 4 | 6. 9 | 45. 3 | 9. 4 | 8. 2 | 10. 2 | 10. 7 | 6. 9 |
| 1966 | 13. 5 | 8. 1 | 6. 6 | 12. 0 | 18. 1 | 6. 9 | 45. 6 | 9. 3 | 8. 0 | 10. 2 | 11. 8 | 6. 5 |
| 1967 | 14. 0 | 10. 4 | 8. 3 | 15. 5 | 17. 4 | 6. 4 | 47. 2 | 9. 7 | 8. 4 | 10. 8 | 13. 3 | 6. 2 |
| 1968 | 12. 1 | 6. 7 | 3. 7 | 13. 8 | 16. 5 | 6. 2 | 46. 4 | 8. 6 | 6. 2 | 9. 7 | 5. 8 | 17. 2 |
| 1969 | 10. 8 | 4. 1 | 2. 2 | 8. 9 | 16. 7 | 5. 9 | 49. 2 | 7. 9 | 6. 9 | 8. 2 | 12. 9 | 10. 8 |
| 1970 | 8. 4 | 4. 2 | 2. 7 | 7. 8 | 12. 5 | 9 | 41. 9 | 3. 8 | 4. 5 | 1. 6 | 18. 0 | 14. 7 |
| 1971 | 9. 9 | 7. 0 | 5. 3 | 10. 9 | 13. 1 | 2. 3 | 46. 2 | 5. 9 | 5. 3 | 4. 3 | 19. 1 | 20. 0 |
| 1972 | 14. 4 | 9. 4 | 8. 0 | 12. 8 | 19. 6 | 10. 0 | 49. 9 | 7. 8 | 6. 9 | 6. 3 | 21. 0 | 13. 3 |
| 1973 | 15. 7 | 9. 5 | 8. 6 | 11. 9 | 22. 1 | 12. 9 | 51. 1 | 9. 0 | 6. 3 | 9. 9 | 19. 8 | 13. 0 |
| 1974 | 12. 8 | 5. 9 | 3. 9 | 10. 5 | 19. 9 | 9. 4 | 53. 7 | 6. 8 | 5. 8 | 4. 9 | 20. 7 | 12. 4 |

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[1] Amounts retained by the organizations for operating expenses, additions to reserves, and profits.

[2] Derived from table 16.

[3] Data by type of plan before 1965 not available.

# Chapter 4. The Patients

## I. Health Status of the American Public

Marked improvements in two key indicators of Americans' health status—average life expectancy and death rates—have been noted since the early 1900's; changes over recent years have been less pronounced. Significant declines in two other key indicators—infant and maternal mortality rates—have been registered since 1950. However, provisional figures for the maternal mortality rates for 1974 show a sharp rise over the rate recorded in 1973.

TABLE 1.—*Key indicators of Americans' health status, selected years*

| | 1920 | 1950 | 1973 | 1974 [1] |
|---|---|---|---|---|
| Birth rates (per 1,000 population) | 27. 7 | 24. 4 | 14. 9 | 15. 0 |
| Death rates (per 1,000 population) | 13. 0 | 9. 6 | 9. 4 | 9. 1 |
| Life expectancy (in years) | 54. 1 | 68. 2 | 71. 3 | 72. 0 |
| Infant mortality (per 1,000 live births) | (2) | 29. 2 | 17. 7 | 16. 5 |
| Maternal mortality (per 100,000 live births) | (2) | 83. 2 | 15. 2 | 20. 8 |

[1] Provisional data.

[2] Not available.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics. Summary report—Final Mortality Statistics, 1973. Monthly Vital Statistics Report (HRA) 75-1120, vol. 23 No. 11, supplement (2), February 10, 1975; and Annual Summary for the United States, 1974, Provisional Statistics. Monthly Vital Statistics Report, vol. 23, No. 13, May 30, 1975.

The statistics on the major causes of death are not as encouraging. During the period from 1950 to 1974, significant increases occurred in the death rates for malignant neoplasms and cirrhosis of the liver, with somewhat smaller increases for diabetes mellitus and suicide. The most notable decreases were for death rates for certain diseases of mortality for early infancy and accidents.

The incidence of acute conditions has declined considerably since 1971. However, the rates for days of disability and activity limitations associated with chronic conditions have generally increased over the period.

The following sections contain summaries of the key indicators of Americans' health status:

A. Life expectancy.
B. Death rates.
C. Infant and maternal mortality.
D. Acute conditions.
E. Chronic conditions.
F. Disability.
G. Communicable diseases.
H. Individual health assessment.

## A. Life Expectancy [1]

Based on the most recent period available for each reporting country, the United States ranks 7th for female and 19th for male life expectancy at birth among the 35 sovereign countries with the highest life expectancy and populations of at least 1 million.

The estimated average length of life in the United States has increased from 54.1 years in 1920 to 72.0 years in 1974. In 1974, white males had an estimated average length of life of 68.9 years, while nonwhite males had a life expectancy of 62.9 years. White females had an estimated average of 76.7 years to live while nonwhite females had an average expectancy of 71.3 years. There is also considerable variation in average lifetime among the 50 States and the District of Columbia. For the period 1969–71, the latest period for which such comparisons are available, Hawaii led the States with a life expectancy of 73.6 years while Washington, D.C., ranked the lowest with 65.7 years.

## B. Death Rates

An estimated 1,933,000 deaths occurred in the United States during 1974, compared with 1,973,003 in 1973. The estimated death rate for 1974 was 9.1 per 1,000 population, a decrease of 0.3 percent compared with the 9.4 rate for 1973. Paralleling the overall decrease was the slight decline in the estimated death rates for most of the leading causes of death. Approximately 73 percent of all deaths occurring in this country in 1974 were attributable to four major causes—heart disease, malignant neoplasms, cerebrovascular diseases, and accidents.

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[1] Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

TABLE 2.—*Death rates from 15 leading causes of death: United States, selected years*

| Rank and cause of death | Death rates 1950 | 1973 | 1974 [1] |
|---|---|---|---|
| All causes | 963. 8 | 940. 2 | 914. 4 |
| 1 Diseases of heart | 356. 8 | 360. 8 | 353. 1 |
| 2 Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues | 139. 8 | 167. 3 | 169. 5 |
| 3 Cerebrovascular diseases | 104. 0 | 102. 1 | 97. 2 |
| 4 Accidents | 60. 6 | 55. 2 | 48. 9 |
| 5 Influenza and pneumonia | [2] 31. 3 | 29. 8 | 25. 7 |
| 6 Diabetes mellitus | 16. 2 | 18. 2 | 17. 4 |
| 7 Cirrhosis of liver | 9. 2 | 15. 9 | 16. 0 |
| 8 Arteriosclerosis | 20. 4 | 15. 5 | 15. 2 |
| 9 Certain causes of mortality in early infancy | 40. 5 | 14. 5 | 13. 2 |
| 10 Suicide | 11. 4 | 12. 0 | 12. 5 |
| 11 Bronchitis, emphysema, and asthma | (3) | 14. 2 | 12. 4 |
| 12 Homicide | 5. 3 | 9. 8 | 9. 8 |
| 13 Congenital anomalies | 12. 2 | 6. 7 | 6. 5 |
| 14 Nephritis and nephrosis | 18. 7 | 4. 0 | 3. 8 |
| 15 Peptic ulcer | 5. 5 | 3. 7 | 3. 3 |
| All other causes | 131. 9 | 110. 5 | 109. 8 |

[1] Preliminary data.
[2] Excludes pneumonia of newborn.
[3] Data not available separately.

Source: U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, Monthly Vital Statistics Report, Summary Report Final Morality Statistics (HRA) 75–1120, vol. 23, No. 11, supplement (2), February 10, 1975. (2) U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, Monthly Vital Statistics Report, Provisional Statistics—Annual Summary for the United States, 1974, vol. 23, No. 13, May 30, 1975. (3) U.S. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States, 1975.

## C. INFANT AND MATERNAL MORTALITY

The 1974 estimated infant mortality rate for the entire U.S. population was 16.5 per 1,000 live births—a 7-percent decrease from the 17.7 rate recorded in 1973. This was the lowest annual rate ever recorded in the United States. Both neonatal (under 28 days) and postneonatal (28 days to 11 mos) mortality rates declined in 1974 with the postneonatal rate showing a proportionately greater decline. Certain gastroentestinal diseases was the only case of infant deaths to show an increase in 1974.

The 1974 estimated infant mortality rate for the United States was 16.5 per 1,000 live births. The figures by race continued to show a higher mortality rate for the nonwhite population—24.6 per 1,000 live births as compared to the white population rate of 14.7. Over the 10-year period 1961–71, the rate for the entire country decreased by 33 percent; this represents a decrease of 31 percent for whites and 40 percent for nonwhites over the period. In 1973 the United States ranked 15th in the world with an infant mortality rate of 17.7.

TABLE 3.—*Infant mortality rates, 1970–74*

[Rates per 1,000 live births]

| | 1970 | 1971 | 1972 | 1973 | 1974 [1] |
|---|---|---|---|---|---|
| Total | 20. 0 | 19. 1 | 18. 5 | 17. 7 | 16. 5 |
| White | 17. 8 | 17. 1 | 16. 4 | 15. 8 | 14. 7 |
| All other | 31. 9 | 28. 5 | 27. 2 | 26. 2 | 24. 6 |

[1] Estimated.

Source: Monthly Vital Statistics Report, Provisional Statistics, Annual Summary for the United States, 1974. U.S. Department of Health Deduction, and Welfare, National Center for Health Statistics, May 30, 1975.

Between 1940 and 1973, the maternal mortality rate decreased from 376 to 15.2 deaths per 100,000 live births. However, in 1974 the estimated rate increased to 20.8 deaths per 100,000 live births.

## D. ACUTE CONDITIONS

During 1974, an estimated 364.3 million acute illnesses or injuries occurred among the civilian noninstitutional population of the United States. The incidence rate of 175.7 per 100 persons per year was roughly the same as the 1973 rate of 175.1, but was considerably less than the rates recorded in 1971 and 1972. Some of this reduction is, however, attributable to the different reporting method used for the National Health Interview Survey beginning in 1973.

Acute illnesses and injuries caused an average of 9.4 days of restricted activity and 4.1 days in bed in 1974. The rate of restricted activity increased from the 8.8-day rate recorded in 1971. There were an estimated 286 million days lost from work attributable to acute illness. The per person work-loss rate declined from 3.8 in 1973 to 3.4 in 1974, while days lost from school per child for those aged 6 to 16 remained at 4.9 over the period.

During 1974, there were an estimated 28.5 persons injured per 100 population, a decrease from the 30.9 figure recorded in 1971. Males continued to have higher rates of injury than did females, and persons under 17 had higher rates than older age groups. About 3 days of restricted activity per person were associated with injury with about 1 day spent in bed.

### TABLE 4.—*Incidence of acute conditions, 1971–74*

[Estimated data for civilian noninstitutional population]

| | Number per 100 persons per year | | | |
|---|---|---|---|---|
| | 1971 | 1972 | 1973 | 1974 |
| All acute conditions | 218. 5 | 219. 7 | 175. 1 | 175. 7 |
| Infective and parasitic diseases | 27. 2 | 22. 9 | 19. 4 | 19. 5 |
| Respiratory conditions | 116. 6 | 120. 8 | 91. 7 | 94. 4 |
| Digestive system conditions | 11. 1 | 11. 2 | 8. 4 | 7. 8 |
| Injuries | 32. 7 | 33. 2 | 30. 7 | 30. 4 |
| All other acute conditions | 30. 9 | 31. 6 | 24. 9 | 23. 5 |

Source: "Current Estimates From the Health Interview Survey, United States, 1974." U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76-1527, September 1975.

### TABLE 5.—*Incidence of acute conditions per 100 persons of all ages by selected demographic characteristic: United States, 1973*

[Rate per 100 persons of all ages]

| Demographic characteristic | All acute conditions | Selected acute conditions | | |
|---|---|---|---|---|
| | | Infective and parasitic | Respiratory | Injuries |
| Total | 175. 1 | 19. 4 | 91. 7 | 30. 7 |
| Sex: | | | | |
| Male | 171. 3 | 18. 9 | 87. 5 | 36. 8 |
| Female | 178. 7 | 19. 9 | 95. 7 | 25. 0 |
| Region: | | | | |
| Northeast | 153. 3 | 24. 7 | 72. 2 | 28. 7 |
| North Central | 185. 4 | 14. 1 | 105. 6 | 30. 0 |
| South | 171. 7 | 24. 7 | 81. 7 | 30. 6 |
| West | 192. 3 | 11. 0 | 115. 0 | 34. 9 |
| Residence: | | | | |
| Metropolitan | 177. 4 | 20. 4 | 91. 6 | 31. 2 |
| Nonmetropolitan | 170. 1 | 17. 2 | 92. 0 | 29. 7 |

NOTE.—Excluded from these statistics are all conditions involving neither restricted activity nor medical attention.

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

### Table 6.—*Days of disability associated with acute conditions, 1971–74*

[Estimated data for civilian noninstitutional population]

| | Rate per person per year | | | |
|---|---|---|---|---|
| | 1971 | 1972 | 1973 | 1974 |
| Restricted activity days | 8. 8 | 9. 5 | 9. 1 | 9. 4 |
| Red-days | 3. 9 | 4. 1 | 4. 0 | 4. 1 |
| Work-loss days (ages 17 and over) [1] | 3. 4 | 3. 7 | 3. 8 | 3. 4 |
| School-loss days (ages 6 to 16) | 5. 0 | 4. 7 | 4. 4 | 4. 9 |

[1] For currently employed population.

Source: "Current Estimates From the Health Interview Survey, United States, 1974." U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76-1527, September 1975.

### Table 7.—*Number of persons injured per 100 persons per year, 1971–74*

[Estimated data for civilian noninstitutional population]

| | 1971 | 1972 | 1973 | 1974 |
|---|---|---|---|---|
| All accidents | 30. 9 | 31. 5 | 29. 1 | 28. 5 |
| Moving motor vehicle | 2. 3 | 2. 3 | 1. 9 | 2. 1 |
| At work | 4. 8 | 3. 9 | 4. 4 | 4. 5 |
| Home | 11. 9 | 11. 8 | 11. 0 | 10. 3 |
| Other | 12. 9 | 14. 5 | 13. 0 | 12. 7 |

Source: "Current Estimates From the Health Interview Survey, United States, 1974." U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76-1527; September 1975.

## E. Chronic Conditions

Approximately 14.1 percent of the population experienced some degree of limitation in their activities in 1974 due to chronic conditions; three-fourths of these persons were limited in a major activity. Four percent of the persons under 17 reported some limitation in their activities while 46 percent of the persons over 65 were limited in their activities by one or more chronic conditions.

In 1972, an estimated 6.5 million persons or 3.2 percent of the civilian noninstitutionalized population had some degree of limitation of mobility due to chronic illness; limitations ranged from being confined to the house to having trouble getting around by themselves. The majority of persons experiencing the mobility limitations were age 65 or over.

TABLE 8.—*Limitation of activity due to chronic conditions, 1971–74*

[Estimated data for civilian noninstitutional population]

| | Percent of total population | | | |
|---|---|---|---|---|
| | 1971 | 1972 | 1973 | 1974 |
| Limited in all activity | 12. 3 | 12. 7 | 13. 5 | 14. 1 |
| Limited in major activity | 9. 3 | 9. 6 | 10. 2 | 10. 6 |
| No limitation of activity | 87. 7 | 87. 3 | 86. 5 | 85. 9 |

Source: "Current Estimates From the Health Interview Survey, United States, 1974," U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76–1527, September 1975.

TABLE 9.—*Persons with limitation of activity due to chronic conditions, by degree of limitation according to sex and age: United States, 1974*

[Estimated data for civilian noninstitutionalized population]

| | Percent distribution | | | |
|---|---|---|---|---|
| Sex and age | Total population | With activity limitation | With limitation in major activity | With no activity limitation |
| Both sexes: | | | | |
| All ages | 100. 0 | 14. 1 | 10. 6 | 85. 9 |
| Under 17 yr | 100. 0 | 3. 7 | 1. 9 | 96. 3 |
| 17 to 44 yr | 100. 0 | 8. 8 | 5. 6 | 91. 2 |
| 45 to 64 yr | 100. 0 | 24. 1 | 18. 9 | 75. 9 |
| 65 yr and over | 100. 0 | 45. 9 | 39. 3 | 54. 1 |
| Male: | | | | |
| All ages | 100. 0 | 14. 3 | 10. 7 | 85. 7 |
| Under 17 yr | 100. 0 | 4. 0 | 2. 1 | 96. 0 |
| 17 to 44 yr | 100. 0 | 9. 2 | 5. 5 | 90. 8 |
| 45 to 64 yr | 100. 0 | 25. 3 | 19. 8 | 74. 7 |
| 65 yr and over | 100. 0 | 49. 7 | 44. 8 | 50. 3 |
| Female: | | | | |
| All ages | 100. 0 | 14. 0 | 10. 5 | 86. 0 |
| Under 17 yr | 100. 0 | 3. 3 | 1. 7 | 96. 7 |
| 17 to 44 yr | 100. 0 | 8. 6 | 5. 8 | 91. 4 |
| 45 to 64 yr | 100. 0 | 23. 0 | 18. 1 | 77. 0 |
| 65 yr and over | 100. 0 | 43. 1 | 35. 3 | 56. 9 |

Source: "Current Estimates From the Health Interview Survey, United States, 1974," U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76–1527, September 1975.

TABLE 10.—*Percent of persons all ages with limitation of mobility by selected demographic characteristics: United States, 1972*

| Demographic characteristic | Population all ages (thousands) | Percent of population of all ages with limitation of mobility | | | |
|---|---|---|---|---|---|
| | | Total | Confined to the house | Needs help in getting around | Has trouble getting around alone |
| Total [1] | 204,148 | 3.2 | 0.9 | 1.0 | 1.3 |
| Sex: | | | | | |
| Male | 98,445 | 2.9 | .8 | .9 | 1.2 |
| Female | 105,704 | 3.4 | 1.0 | 1.1 | 1.3 |
| Color: | | | | | |
| White | 178,727 | 3.1 | .8 | 1.0 | 1.2 |
| All other | 25,421 | 3.7 | 1.2 | 1.0 | 1.6 |
| Region: | | | | | |
| Northeast | 48,011 | 3.1 | 1.0 | 1.0 | 1.1 |
| North Central | 55,974 | 2.7 | .6 | 1.0 | 1.1 |
| South | 64,128 | 3.9 | 1.1 | 1.1 | 1.6 |
| West | 36,036 | 2.7 | .7 | .9 | 1.1 |
| Residence: | | | | | |
| Metropolitan | 131,100 | 2.9 | .8 | .9 | 1.1 |
| Nonmetropolitan | 73,049 | 3.7 | .9 | 1.2 | 1.6 |
| Family income: | | | | | |
| Under $5,000 | 40,835 | 8.6 | 2.6 | 2.7 | 3.2 |
| $5,000 to $9,999 | 59,134 | 2.5 | .6 | .8 | 1.1 |
| $10,000 to $14,999 | 51,074 | 1.3 | .3 | .4 | .6 |
| $15,000 and over | 40,983 | 1.1 | .2 | .4 | .5 |

[1] Includes unknown income.

Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare.

Among reported chronic conditions, arthritis and hearing impairments rank 1st and 2d, respectively. However, heart conditions cause more limitation of activity than any other condition.

TABLE 11.—*Prevalence of selected chronic conditions reported in health interviews and selected measures of impact: all ages, United States*

| Prevalence and impact of conditions | Arthritis (1969) | Asthma (1970) | Chronic bronchitis (1970) | Diabetes (1973) | Heart conditions (1972) | Hypertensive disease [1] (1972) | Visual impairments (1972) | Hearing impairments (1971) |
|---|---|---|---|---|---|---|---|---|
| Number of conditions (thousands) | 18, 339. 0 | 6, 031. 0 | 6, 526. 0 | 4, 191. 0 | 10, 291. 0 | 12, 271. 0 | 9, 596. 0 | 14, 491. 0 |
| Number per 1,000 persons | 92. 9 | 30. 2 | 32. 7 | 20. 4 | 50. 4 | 60. 1 | 47. 4 | 71. 6 |
| Percent of conditions— | | | | | | | | |
| Causing activity limitation | 17. 6 | 17. 1 | 4. 0 | 29. 7 | 41. 6 | 8. 9 | 12. 5 | 4. 0 |
| With doctor visit in past year | 41. 6 | 60. 3 | 71. 5 | 82. 6 | 75. 2 | 80. 7 | 36. 2 | 21. 0 |
| Ever hospitalized | 7. 6 | 19. 1 | 14. 3 | 29. 4 | 41. 0 | 7. 1 | [2] | [2] |
| Under medical treatment | 36. 4 | 51. 4 | 19. 9 | 73. 6 | 58. 6 | 59. 5 | [3] | [3] |
| With 1 or more bed days in past year | 8. 1 | 31. 7 | 47. 1 | 13. 6 | 21. 6 | 6. 9 | 2. 3 | 1. 6 |
| With 15 or more bed days in past year | 3. 1 | 5. 2 | 5. 8 | 4. 4 | 10. 5 | 1. 4 | . 4 | . 1 |

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[1] Without heart involvement.

[2] Not available.

Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

## F. DISABILITY

There were an estimated 17.2 days of restricted activity per person in 1974 as a result of chronic and acute illnesses or injuries; this represents an increase of 0.7 days from the previous year and 1.5 days since 1971. The number of restricted activity days per person ranged from about 10.7 days for children under age 17 to 38.0 days for persons 65 years and over. The average number of bed days remained relatively constant from 1971 to 1974; 6.7 days per person was recorded in 1974.

There were an estimated 414 million days lost from work due to illness or injury in 1974, or an average of 4.9 days per currently employed person over age 17. The number of days lost from school for children age 6 to 16 years was 5.6 days per person for the same period. Females generally reported more restricted activity, and bed and work-loss days than did males.

TABLE 12.—*Days of disability and limitation of activity: United States, 1971–74*

[Estimated data for civilian noninstitutional population]

| | Days of disability per person per year | | | |
|---|---|---|---|---|
| | 1971 | 1972 | 1973 | 1974 |
| Restricted activity days | 15. 7 | 16. 7 | 16. 5 | 17. 2 |
| Bed days | 6. 1 | 6. 5 | 6. 4 | 6. 7 |
| Work-loss days (ages 17 and over) [1] | 5. 1 | 5. 3 | 5. 4 | 4. 9 |
| School-loss days (ages 6 to 16) | 5. 5 | 5. 3 | 5. 1 | 5. 6 |

[1] For currently employed population.

Source: "Current Estimates From the Health Interview Survey, United States, 1974" U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76–1527, September 1975.

TABLE 13.—*Days of disability per person per year by sex and age, 1974*

[Estimated data for civilian noninstitutional population]

| Sex and age | Restricted activity | Bed-disability days | Work-lost days [1] | Days lost from school [2] |
|---|---|---|---|---|
| Total population, all ages | 17. 2 | 6. 7 | 4. 9 | ------------ |
| Under 17 yr | 10. 7 | 4. 8 | ------------ | 5. 6 |
| 17 to 24 yr | 11. 2 | 4. 6 | 4. 4 | ------------ |
| 25 to 44 yr | 14. 8 | 5. 8 | 4. 6 | ------------ |
| 45 to 64 yr | 23. 6 | 8. 4 | 5. 8 | ------------ |
| 65 yr and over | 38. 0 | 14. 3 | 4. 4 | ------------ |
| Males, all ages | 15. 6 | 5. 8 | 4. 8 | ------------ |
| Under 17 yr | 11. 1 | 4. 8 | ------------ | 5. 7 |
| 17 to 24 yr | 9. 4 | 3. 3 | 3. 9 | ------------ |
| 25 to 44 yr | 12. 5 | 4. 5 | 4. 3 | ------------ |
| 45 to 64 yr | 22. 0 | 7. 4 | 5. 9 | ------------ |
| 65 yr and over | 36. 8 | 14. 2 | 5. 6 | ------------ |
| Females, all ages | 18. 7 | 7. 5 | 5. 1 | ------------ |
| Under 17 yr | 10. 3 | 4. 8 | ------------ | 5. 5 |
| 17 to 24 yr | 12. 8 | 5. 8 | 5. 0 | ------------ |
| 25 to 44 yr | 17. 0 | 7. 0 | 5. 2 | ------------ |
| 45 to 64 yr | 25. 1 | 9. 4 | 5. 5 | ------------ |
| 65 yr and over | 38. 8 | 14. 4 | (3) | ------------ |

[1] Work loss reported for currently employed persons aged 17 yr and over.

[2] School days lost reported for children ages 6 to 16 yr.

[3] Less than 0.1 percent.

Source: "Current Estimates From the Health Interview Survey, United States, 1974," U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76–1527, September 1975.

TABLE 14.—*Number of disability days per person per year, by selected demographic characteristics: United States, 1973*

[Days per person]

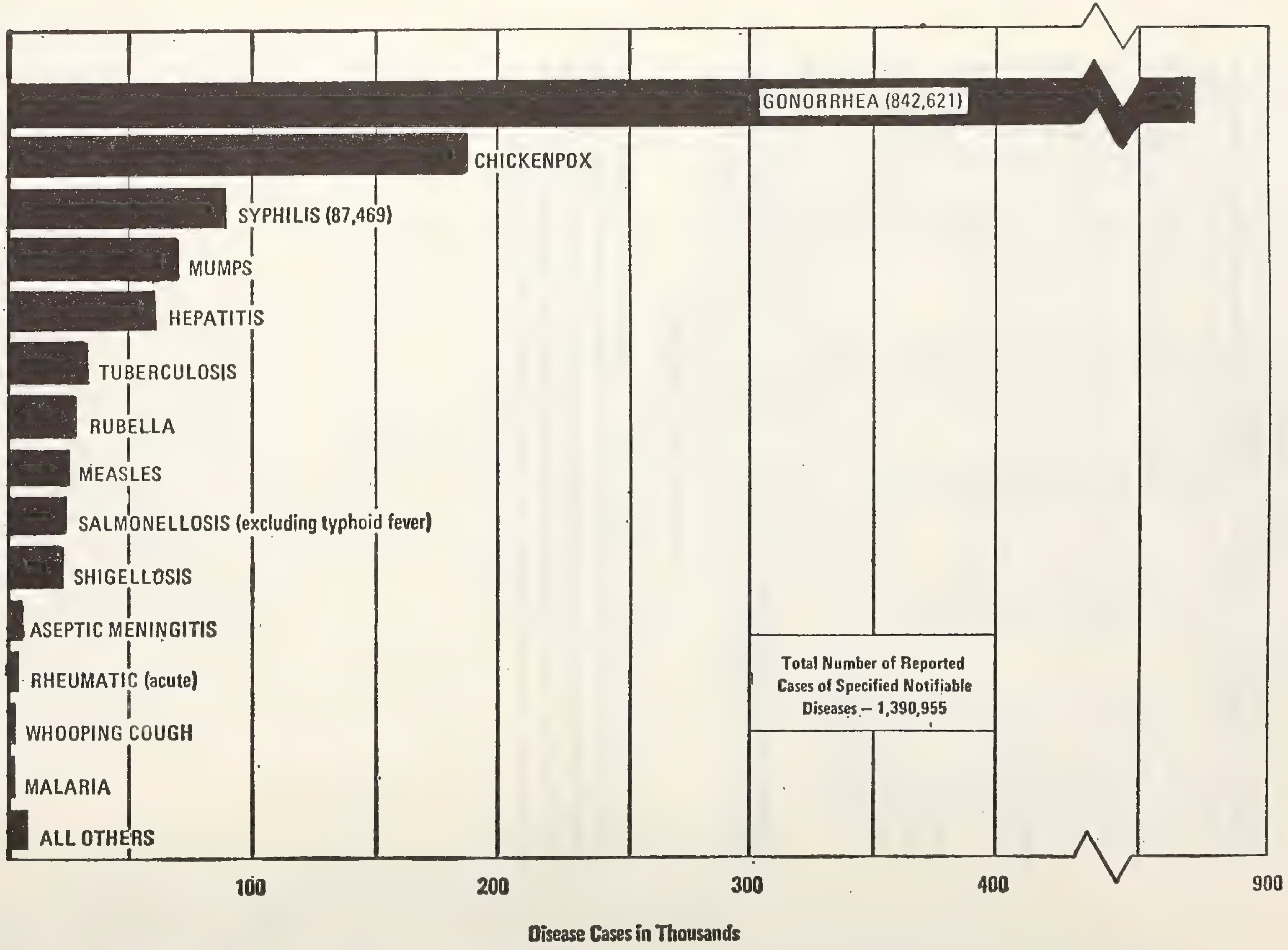
| Demographic characteristic | Restricted activity days | Bed disability days | Work loss days |
|---|---|---|---|
| Total | 16. 5 | 6. 4 | 5. 4 |
| Sex: | | | |
| Male | 14. 7 | 5. 3 | 5. 2 |
| Female | 18. 1 | 7. 3 | 5. 8 |
| Color: | | | |
| White | 16. 1 | 6. 1 | 5. 3 |
| All other | 18. 8 | 8. 0 | 6. 7 |
| Region: | | | |
| Northeast | 13. 9 | 5. 5 | 5. 2 |
| North Central | 15. 5 | 5. 8 | 5. 2 |
| South | 18. 4 | 7. 4 | 5. 9 |
| West | 18. 1 | 6. 6 | 5. 2 |
| Residence: | | | |
| Metropolitan | 16. 3 | 6. 4 | 5. 6 |
| Nonmetropolitan | 16. 9 | 6. 2 | 5. 0 |
| Family income: | | | |
| Under $5,000 | 28. 8 | 10. 7 | 6. 8 |
| $5,000 to $9,999 | 16. 5 | 6. 5 | 6. 3 |
| $10,000 to $14,999 | 13. 0 | 5. 2 | 5. 1 |
| $15,000 and over | 12. 2 | 4. 5 | 4. 9 |

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

## G. COMMUNICABLE DISEASES

There were 1,390,955 reported cases of communicable disease in the United States in 1973. Gonorrhea ranked first, chickenpox second, and syphilis third. When underreporting and undetected cases are considered, it is estimated that 2.7 million cases of gonorrhea occur each year. The following table shows by illness the number of instances of specified notifiable diseases in 1973.

TABLE 15.—*Communicable diseases—Number of reported cases, United States, calendar year 1973*



Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

### H. Individual Health Assessment

In general, the American people think of themselves as being in good health. As part of the National Health Interview Survey, persons were asked to compare their health with other persons their own age. Eighty-seven percent regarded their health as excellent or good, 9 percent as fair, and only 3 percent as poor. Males were more likely than females, and whites more likely than nonwhites to report excellent health.

Table 16.—*Assessment of health status as reported in health interviews for persons of all ages, according to selected demographic characteristics: United States, 1973*

[Percent distribution]

| Demographic characteristic | Health status, all ages | | | | |
|---|---|---|---|---|---|
| | Total | Excellent | Good | Fair | Poor |
| Total [1] | 100. 0 | 48. 7 | 38. 4 | 9. 4 | 2. 8 |
| Sex: | | | | | |
| Male | 100. 0 | 51. 9 | 36. 5 | 8. 3 | 2. 7 |
| Female | 100. 0 | 45. 7 | 40. 2 | 10. 6 | 2. 9 |
| Color: | | | | | |
| White | 100. 0 | 50. 4 | 37. 6 | 8. 8 | 2. 6 |
| All other | 100. 0 | 36. 7 | 44. 2 | 14. 1 | 4. 2 |
| Region: | | | | | |
| Northeast | 100. 0 | 48. 6 | 40. 3 | 8. 2 | 2. 2 |
| North central | 100. 0 | 50. 3 | 38. 1 | 8. 8 | 2. 3 |
| South | 100. 0 | 44. 4 | 39. 6 | 11. 4 | 3. 9 |
| West | 100. 0 | 54. 1 | 34. 3 | 8. 6 | 2. 5 |
| Residence: | | | | | |
| Metropolitan | 100. 0 | 50. 4 | 37. 8 | 8. 7 | 2. 4 |
| Nonmetropolitan | 100. 0 | 44. 8 | 39. 9 | 11. 1 | 3. 7 |
| Family income: | | | | | |
| Under $5,000 | 100. 0 | 32. 4 | 41. 3 | 17. 9 | 7. 7 |
| $5,000 to $9,999 | 100. 0 | 44. 5 | 41. 4 | 10. 9 | 2. 6 |
| $10,000 to $14,999 | 100. 0 | 53. 0 | 38. 1 | 6. 7 | 1. 6 |
| $15,000 and over | 100. 0 | 60. 7 | 33. 2 | 4. 7 | . 8 |

[1] Includes unknown income.

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

## II. Health Services Utilization Patterns of the American Public

The following sections contain an analysis of the utilization patterns of health care services by the American population.

A. Hospital utilization.
B. Physician visits.
C. Dental visits.
D. Utilization of preventive care services.
E. Utilization of mental health care and mental retardation facilities.
F. Long-term care utilization.

### A. Hospital Utilization

In 1974 there were 35.5 million admissions to over 7,000 hospitals in the United States. Approximately 426 million inpatient days and 250 million outpatient visits were recorded during this period.

The most commonly used data on hospital utilization are based on figures obtained for community hospitals, i.e., short-term general and other special hospitals (excluding Federal hospitals which are not generally available to the public). Community hospitals represent about 82 percent of all hospitals, handle over 93 percent of all admissions and 75 percent of all outpatient visits, employ 78 percent of the industry's total labor force, and account for 79 percent of the total cost of hospital care.

In 1974 there were approximately 32.9 million admissions to community hospitals, 255 million patient days and 189 million outpatient visits. The average length of stay was 7.8 days; this included an average stay of 7.9 days in nonprofit hospitals, 7.7 days in State and local government hospitals, and 6.7 days in for-profit hospitals. The larger hospitals tend to have longer lengths of stay than smaller community hospitals. This reflects the fact that such hospitals, generally located in urban areas, tend to offer a broader range of services and serve a population consisting of relatively more aged and poor persons.

The Health Interview Survey conducted by the National Center for Health Statistics (which is based on sampling data that includes some Federal hospitals) showed that approximately 10.7 percent of the population was hospitalized at least once in 1974; this figure represented at least one hospital episode for 8.8 percent of the male population and 12.5 percent of the female population. While only 5.7 percent of the persons under 17 had been hospitalized, 16.8 percent of the population 65 and over had received such care.

TABLE 17.—*Hospital utilization: Admissions, inpatient days, outpatient visits, percent occupancy, average stay, and surgical operations, 1974*

| | Admissions (thousands) | Inpatient days (thousands) | Outpatient visits (thousands) | Occupancy (percent) | Average stay (days) | Surgical operation (thousands) |
|---|---|---|---|---|---|---|
| United States, total | 35, 506 | 425, 878 | 250, 481 | 77. 2 | (1) | 16, 937 |
| Federal | 1, 841 | 39, 936 | 48, 682 | 80. 7 | (1) | 658 |
| Non-Federal | 33, 666 | 385, 942 | 201, 799 | 76. 8 | (1) | 16, 279 |
| Psychiatric | 595 | 111, 962 | 5, 240 | 80. 0 | (1) | 25 |
| Tuberculosis | 21 | 1, 884 | 91 | 63. 2 | (1) | 7 |
| Long-term general and other special | 106 | 16, 335 | 1, 630 | 82. 5 | (1) | 31 |
| Short-term general and other special | 32, 943 | 255, 762 | 194, 838 | 75. 3 | (1) | 16, 217 |
| Hospital units of institutions | 77 | 568 | 5, 899 | 30. 4 | | 23 |
| Community hospitals | 32, 866 | 255, 193 | 188, 940 | 75. 6 | 7. 8 | 16, 193 |
| Nongovernment nonprofit | 23, 359 | 184, 467 | 130, 438 | 77. 9 | 7. 9 | 12, 270 |
| Investor-owned (for profit) | 2, 553 | 17, 078 | 8, 667 | 67. 5 | 6. 7 | 1, 233 |
| State and local governmental | 6, 953 | 53, 649 | 49, 835 | 71. 0 | 7. 7 | 2, 690 |

[1] Not available.

Note.—Totals may not add due to rounding.

Source: "Hospital Statistics, 1974," American Hospital Association, 1975.

TABLE 18.—*Selected measures of hospital utilization in all U.S. hospitals, 1964, 1973, 1974*

| Measure | All U.S. hospitals | | | | | Community hospitals | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Percent change | | | | | Percent change | |
| | 1964 | 1973 | 1974 | 1964–74 | 1973–74 | 1964 | 1973 | 1974 | 1964–74 | 1973–74 |
| Hospitals | 7, 127. 0 | 7, 123. 0 | 7, 174. 0 | 0. 7 | 0. 7 | 5, 712. 0 | 5, 789. 0 | 5, 875. 0 | 2. 9 | 1. 5 |
| Beds (thousands) | 1, 696. 0 | 1, 535. 0 | 1, 513. 0 | −10. 8 | −1. 4 | 721. 0 | 898. 0 | 926. 0 | 28. 4 | 3. 1 |
| Beds per thousand population [1] | 8. 9 | 7. 3 | 7. 2 | 18. 0 | −1. 4 | 3. 8 | 4. 3 | 4. 4 | 13. 1 | 2. 3 |
| Admissions (thousands) | 28, 266. 0 | 34, 352. 0 | 35, 506. 0 | 25. 6 | 3. 4 | 25, 987. 0 | 31, 671. 0 | 32, 866. 0 | 26. 5 | 3. 8 |
| Admissions per thousand population [1] | 148. 0 | 164. 0 | 168. 0 | 10. 8 | 2. 4 | 138. 0 | 152. 0 | 15. 7 | 10. 1 | 3. 3 |
| Average daily census | 1, 421. 0 | 1, 189. 0 | 1, 167. 0 | −17. 9 | −1. 9 | 550. 0 | 680. 0 | 700. 0 | 27. 3 | 2. 9 |
| Average length of stay, days | (2) | (2) | (2) | ---------- | ---------- | 7. 7 | 7. 8 | 7. 8 | 1. 3 | ---------- |
| Occupancy, percent | 83. 8 | 77. 5 | 77. 2 | −7. 9 | −0. 4 | 76. 3 | 75. 7 | 75. 6 | −. 9 | −. 1 |
| Outpatient visits (thousands) | [3] 125, 123. 0 | 233, 555. 0 | 250, 481. 0 | 100. 2 | 7. 2 | [3] 91, 430. 0 | 173, 068. 0 | 188, 940. 0 | 106. 6 | 9. 2 |
| Outpatient visits per thousand population [1] | (2) | 1, 112. 9 | 1, 184. 9 | ---------- | 6. 5 | (2) | 831. 7 | 901 | ---------- | 8. 3 |

[1] Population figures used are total resident population for all U.S. hospitals and total civilian resident population for community hospitals.

[2] Comparable data not available.

[3] Based only on hospitals reporting outpatient visits.

Source: "Hospital Statistics, 1974" American Hospital Association, 1975.

TABLE 19.—*Average length of stay in community hospitals by bed sizes, 1974*

| *Hospital bed size* | *Average length of stay* |
|---|---|
| All sizes | 7. 8 |
| 6 to 24 | 5. 8 |
| 25 to 49 | 6. 1 |
| 50 to 99 | 6. 9 |
| 100 to 199 | 7. 2 |
| 200 to 299 | 7. 5 |
| 300 to 399 | 7. 9 |
| 400 to 499 | 8. 2 |
| 500 or more | 9. 2 |

Source: "Hospital Statistics, 1974," American Hospital Association, 1975.

TABLE 20.—*Percent distribution of persons with short-stay hospital episodes during the past year by number of episodes, according to sex and age: United States, 1974. Data are based on household interviews of the civilian, noninstitutionalized population*

| Sex and age | Population | Number of hospital episodes | | | |
|---|---|---|---|---|---|
| | | None | 1 | 2 | 3 plus |
| Both sexes, all ages | 100. 0 | 89. 3 | 8. 9 | 1. 3 | 0. 5 |
| Under 17 years | 100. 0 | 94. 3 | 5. 0 | . 5 | . 1 |
| 17 to 24 years | 100. 0 | 88. 7 | 9. 9 | 1. 1 | . 3 |
| 25 to 34 years | 100. 0 | 86. 7 | 11. 5 | 1. 4 | . 4 |
| 35 to 44 years | 100. 0 | 88. 8 | 9. 2 | 1. 4 | . 6 |
| 45 to 64 years | 100. 0 | 87. 3 | 10. 1 | 1. 9 | . 7 |
| 65 years and over | 100. 0 | 83. 2 | 12. 7 | 2. 9 | 1. 2 |
| Male, all ages | 100. 0 | 91. 2 | 7. 2 | 1. 2 | . 4 |
| Under 17 years | 100. 0 | 94. 1 | 5. 2 | . 6 | . 2 |
| 17 to 24 years | 100. 0 | 93. 8 | 5. 4 | . 6 | * |
| 25 to 34 years | 100. 0 | 92. 9 | 6. 0 | . 8 | . 3 |
| 35 to 44 years | 100. 0 | 91. 9 | 6. 6 | 1. 0 | . 5 |
| 45 to 64 years | 100. 0 | 87. 1 | 10. 1 | 2. 0 | . 8 |
| 65 years and over | 100. 0 | 82. 0 | 13. 2 | 3. 5 | 1. 3 |
| Female, all ages | 100. 0 | 87. 5 | 10. 5 | 1. 5 | . 5 |
| Under 17 years | 100. 0 | 94. 6 | 4. 9 | . 4 | . 1 |
| 17 to 24 years | 100. 0 | 83. 9 | 14. 2 | 1. 5 | . 4 |
| 25 to 34 years | 100. 0 | 80. 9 | 16. 6 | 2. 1 | . 4 |
| 35 to 44 years | 100. 0 | 86. 0 | 11. 5 | 1. 7 | . 7 |
| 45 to 64 years | 100. 0 | 87. 4 | 10. 2 | 1. 9 | . 6 |
| 65 years and over | 100. 0 | 84. 0 | 12. 3 | 2. 5 | 1. 1 |

Source: "Current Estimates from the Health Interview Survey, United States—1974." U.S. Department of Health, Education and Welfare, National Center for Health Statistics, DHEW Publication No. (HRA) 76–1527.

The rate of hospitalization, the number of days of care per 1,000 population, and the average length of stay increase with age and decrease as income rises.

TABLE 21.—*Discharges from short-stay hospitals per 1,000 population, days of hospital care per 1,000 population, and average length of stay by sex, age, geographic region and family income: United States, 1973*

| Sex, age, region, and income | Population (thousands) | Discharges per 1,000 population | Days of care per 1,000 population | Average length of stay in days |
|---|---|---|---|---|
| Total | 205, 836 | 160 | 1, 238 | 7. 8 |
| Male | 99, 307 | 132 | 1, 090 | 8. 3 |
| Female | 106, 529 | 185 | 1, 375 | 7. 4 |
| Age: | | | | |
| 0 to 14 years | 55, 559 | 72 | 329 | 4. 6 |
| 15 to 44 years | 87, 342 | 158 | 898 | 5. 7 |
| 45 to 64 years | 42, 641 | 186 | 1, 698 | 9. 1 |
| 65 years and over | 20, 294 | 350 | 4, 228 | 12. 1 |
| Region: | | | | |
| Northeast | 48, 940 | 148 | 1, 334 | 9. 0 |
| North-central | 56, 772 | 178 | 1, 426 | 8. 0 |
| South | 64, 499 | 160 | 1, 169 | 7. 3 |
| West | 35, 625 | 146 | 930 | 6. 4 |
| Family income: | | | | |
| Under $5,000 | 34, 931 | 236 | 2, 297 | 9. 6 |
| $5,000 to $9,999 | 51, 628 | 172 | 1, 349 | 7. 9 |
| $10,000 to $14,999 | 50, 924 | 133 | 873 | 6. 5 |
| $15,000 and over | 53, 549 | 126 | 800 | 6. 4 |

## B. PHYSICIAN VISITS

In 1974, there were approximately 1 billion visits to medical doctors (excluding visits to patients in hospitals) for the civilian noninstitutional population, or an average of 4.9 visits per person per year. This figure is about equal to the rates which were recorded in the preceding 3 years (4.9 visits in 1971 and 5.0 visits in 1972 and 1973). The number of visits per person ranged from 4.1 visits for children to 6.5 visits for persons 75 years old and over. In 1974, females continued to have more doctor visits than did males in all age groups for those under age 17.

Almost 75 percent of the civilian noninstitutional population saw a medical doctor at least once during the preceding 12 months. This figure was highest for those persons over age 65; however, 6.7 percent of this population group had not seen a physician in the past 5 years. Females of child bearing age had more visits during the preceding 12 months than did females in the remaining age groups.

TABLE 22.—*Physician visits for civilian noninstitutional population, 1971–74*

| | 1971 | 1972 | 1973 | 1974 |
|---|---|---|---|---|
| Number per person per year | 4. 9 | 5. 0 | 5. 0 | 4. 9 |
| Percent of persons with visits in past year | 72. 4 | 72. 6 | 74. 5 | 75. 3 |

Source: "Current Estimates From the Health Interview Survey, United States, 1974." U.S. Department of Health, Education, and Welfare, National Center for Health Statistics. DHEW publication No. (11HRA) 76–1527, September 1973.

Table 23.—*Number of physician visits per person per year, by age and sex, United States, 1974 (for civilian noninstitutional population)*

| Sex | All ages | Under 17 yr | 17–24 yr | 25–44 yr | 45–64 yr | 65–74 yr | 75 yr and over |
|---|---|---|---|---|---|---|---|
| Both sexes | 4.9 | 4.1 | 4.5 | 5.0 | 5.5 | 6.9 | 6.5 |
| Male | 4.3 | 4.3 | 3.2 | 3.5 | 4.9 | 6.8 | 6.3 |
| Female | 5.6 | 4.0 | 5.8 | 6.3 | 6.1 | 6.9 | 6.6 |

Source: "Current Estimates From the Health Interview Survey, United States, 1974," U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76–1527.

Table 24.—*Number and percent distribution of persons by time interval since last physician visit, according to sex and age: United States, 1974*

[Data are based on household interviews of the civilian, noninstitutionalized population]

| Sex and age | Total population | Time interval since last physician visit (percent distribution) | | | |
|---|---|---|---|---|---|
| | | Under 1 yr | 1 to 4 yr | 5 yr and over | Other [1] |
| Both sexes: | | | | | |
| All ages | 100.0 | 75.3 | 20.1 | 3.8 | 0.8 |
| Under 17 yr | 100.0 | 74.3 | 22.1 | 2.5 | 1.2 |
| 17 to 24 yr | 100.0 | 77.0 | 19.9 | 2.2 | .9 |
| 25 to 44 yr | 100.0 | 76.2 | 19.7 | 3.4 | .4 |
| 45 to 64 yr | 100.0 | 73.9 | 19.8 | 5.7 | .6 |
| 65 yr and over | 100.0 | 77.2 | 15.6 | 6.7 | .5 |
| Male: | | | | | |
| All ages | 100.0 | 71.2 | 23.4 | 4.5 | 1.0 |
| Under 17 yr | 100.0 | 75.0 | 21.6 | 2.4 | 1.0 |
| 17 to 24 yr | 100.0 | 69.1 | 26.9 | 2.9 | 1.2 |
| 25 to 44 yr | 100.0 | 67.8 | 26.2 | 5.1 | .7 |
| 45 to 64 yr | 100.0 | 69.4 | 23.1 | 6.8 | .7 |
| 65 yr and over | 100.0 | 74.6 | 17.4 | 7.5 | (2) |
| Female: | | | | | |
| All ages | 100.0 | 79.3 | 16.9 | 3.1 | .7 |
| Under 17 yr | 100.0 | 73.5 | 22.6 | 2.6 | 1.3 |
| 17 to 24 yr | 100.0 | 84.4 | 13.4 | 1.5 | .5 |
| 25 to 44 yr | 100.0 | 83.9 | 13.8 | 1.9 | .3 |
| 45 to 64 yr | 100.0 | 77.9 | 16.8 | 4.8 | .3 |
| 65 yr and over | 100.0 | 79.2 | 14.3 | 6.1 | .4 |

[1] "Other" includes "never" and "unknown".

[2] Less than 0.1 percent.

Note: Numbers may not add due to rounding.

Source: "Current Estimates From the Health Interview Survey United States 1974", U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHFW publication No. (HRA) 76–1527, September 1975.

Utilization of physician services varies considerably among different segments of the population. Females see a physician more frequently than males, and white persons more frequently than nonwhite persons. Over the decade 1964–73 there was an appreciable increase in the number of physician visits per poor person per year, and a notable decrease in the number of poor who had no physician visits in the preceding 2 years. Over two-thirds of all outpatient physician contacts occur at the physician's office, with the poor and minorities using hospital outpatient clinics more frequently than other segments of the population. The following tables highlight the significant demographic variables in physician visit patterns.

TABLE 25.—*Number of physician visits per person per year and percent of the population with no physician visits in the past 2 years by poor and not poor status, and color for all ages: 1964 and 1973*

| Age and year | Total | | White | | All other | |
|---|---|---|---|---|---|---|
| | Poor | Not poor | Poor | Not poor | Poor | Not poor |
| All ages—Number of physician visits per person per year: | | | | | | |
| 1964 | 4.3 | 4.6 | 4.7 | 4.7 | 3.1 | 3.6 |
| 1973 | 5.6 | 4.9 | 5.7 | 5.0 | 5.0 | 4.3 |
| All ages—Percent with no physician visits in past 2 yr: | | | | | | |
| 1964 | 27.7 | 17.7 | 25.7 | 17.1 | 33.2 | 24.7 |
| 1973 | 17.2 | 13.4 | 16.8 | 13.2 | 18.5 | 15.3 |

NOTE.—Definition of poor is based on family income: Under $3,000 in 1964; under $6,000 in 1973. In each case, this included about 1/5 of the population.

Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

TABLE 26.—*Number of physician visits per person per year and percent of population with one or more visits in past year by selected demographic characteristic: Persons of all ages, United States, 1973*

| Demographic characteristic | Number of visits per person per year | Percent with physician visit in past year |
|---|---|---|
| Total [1] | 5.0 | 74.5 |
| Sex: | | |
| Male | 4.3 | 70.4 |
| Female | 5.6 | 78.3 |
| Color: | | |
| White | 5.1 | 75.1 |
| All other | 4.5 | 70.7 |
| Region: | | |
| Northeast | 4.9 | 75.5 |
| North Central | 5.0 | 74.3 |
| South | 4.0 | 73.7 |
| West | 5.4 | 74.9 |
| Residence: | | |
| Metropolitan | 5.2 | 75.7 |
| Nonmetropolitan | 4.5 | 71.8 |
| Family income: | | |
| Under $5,000 | 5.7 | 73.8 |
| $5,000 to $9,999 | 4.8 | 72.9 |
| $10,000 to $14,999 | 4.9 | 75.3 |
| $15,000 and over | 5.1 | 77.4 |

[1] Includes unknown income.

Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

TABLE 27.—*Physician visits by place of visit by selected demographic characteristic: Persons of all ages, United States, 1973*

[Percent distribution]

| Demographic characteristic | Total visits [1] (thousands) | Office | Hospital out-patient clinic | Hospital emergency room | Telephone | Home |
|---|---|---|---|---|---|---|
| Total [2] | 1, 031, 010 | 69. 1 | 6. 8 | 3. 9 | 12. 7 | 1. 4 |
| Sex: | | | | | | |
| Male | 429, 734 | 67. 8 | 6. 8 | 4. 7 | 11. 5 | 1. 5 |
| Female | 601, 276 | 70. 0 | 6. 8 | 3. 3 | 13. 6 | 1. 3 |
| Color: | | | | | | |
| White | 914, 208 | 70. 2 | 5. 6 | 3. 5 | 13. 6 | 1. 5 |
| All other | 116, 802 | 60. 1 | 16. 4 | 7. 0 | 5. 9 | . 9 |
| Region: | | | | | | |
| Northeast | 241, 030 | 65. 7 | 7. 9 | 4. 7 | 12. 6 | 2. 8 |
| North Central | 284, 012 | 70. 1 | 6. 0 | 3. 4 | 14. 3 | 1. 2 |
| South | 314, 792 | 68. 9 | 7. 1 | 3. 8 | 12. 0 | 1. 0 |
| West | 191, 155 | 72. 0 | 6. 0 | 3. 6 | 11. 6 | . 4 |
| Residence: | | | | | | |
| Metropolitan | 742, 845 | 67. 1 | 7. 5 | 4. 1 | 13. 5 | 1. 5 |
| Nonmetropolitan | 288, 165 | 74. 2 | 5. 0 | 3. 3 | 10. 7 | 1. 1 |
| Family income: | | | | | | |
| Under $5,000 | 199, 710 | 65. 2 | 10. 5 | 3. 8 | 9. 6 | 1. 9 |
| $5,000 to $9,999 | 249, 207 | 71. 4 | 6. 7 | 4. 0 | 11. 5 | 1. 3 |
| $10,000 to $14,999 | 251, 453 | 68. 4 | 5. 7 | 4. 0 | 15. 3 | . 8 |
| $15,000 and over | 270, 842 | 70. 0 | 4. 9 | 3. 8 | 14. 3 | 1. 8 |

[1] Includes all other places of visits.
[2] Includes unknown income.

Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

Information obtained from the National Ambulatory Medical Care Survey shows that the number of office visits to physicians increases with age. Higher levels of visits are recorded for females and whites and in metropolitan areas. For the whole population, over half of the visits are for conditions which the physician judges to be not serious while for the aged only one-third are for nonserious problems. Close to half of the office visits involve some form of drug therapy (including prescription and nonprescription drugs) while over a third of such visits involve a general history or examination. Sixty-one percent of the patients are told to return to the physician at a specified time while 21 percent are told to return if necessary. For 13 percent no followup care is planned. Referrals and hospital admissions are rare.

TABLE 28.—*Rate of visits to physicians offices by patient's age, according to patient's sex and color and region and location of visit: United States, May 1973–April 1974 (from National Ambulatory Medical Care Survey)*

[Number of visits per person]

| Sex and color and region and location of visit | Total | Age<br>Under 15 yr | 15 to 24 yr | 25 to 44 yr | 45 to 64 yr | 65 yr and over |
|---|---|---|---|---|---|---|
| Color and sex: | | | | | | |
| Total | 3. 1 | 2. 3 | 2. 6 | 3. 2 | 3. 8 | 4. 9 |
| Male | 2. 5 | 2. 3 | 1. 9 | 2. 1 | 3. 2 | 4. 5 |
| Female | 3. 7 | 2. 2 | 3. 4 | 4. 2 | 4. 3 | 5. 2 |
| White | 3. 2 | 2. 4 | 2. 7 | 3. 1 | 3. 8 | 5. 0 |
| Male | 2. 6 | 2. 5 | 2. 0 | 2. 1 | 3. 2 | 4. 6 |
| Female | 3. 7 | 2. 3 | 3. 4 | 4. 1 | 4. 3 | 5. 3 |
| All other | 2. 6 | 1. 5 | 2. 4 | 3. 4 | 3. 7 | 4. 0 |
| Male | 2. 0 | 1. 4 | 1. 3 | 2. 1 | 3. 4 | 3. 7 |
| Female | 3. 2 | 1. 6 | 3. 3 | 4. 3 | 4. 0 | 4. 2 |
| Region: | | | | | | |
| Northeast | 3. 1 | 2. 4 | 2. 8 | 3. 3 | 3. 6 | 4. 3 |
| North Central | 3. 0 | 2. 2 | 2. 6 | 3. 0 | 3. 6 | 4. 9 |
| South | 3. 1 | 2. 4 | 2. 6 | 3. 2 | 3. 8 | 4. 8 |
| West | 3. 2 | 1. 9 | 2. 6 | 3. 3 | 4. 2 | 6. 2 |
| Location of visits: | | | | | | |
| Metropolitan area | 3. 4 | 2. 3 | 2. 8 | 3. 6 | 4. 2 | 5. 4 |
| Male | 2. 7 | 2. 4 | 2. 0 | 2. 3 | 3. 5 | 5. 0 |
| Female | 4. 0 | 2. 3 | 3. 7 | 4. 7 | 4. 8 | 5. 6 |
| Nonmetropolitan area | 2. 5 | 2. 1 | 2. 2 | 2. 2 | 2. 9 | 4. 1 |
| Male | 2. 2 | 2. 2 | 1. 6 | 1. 6 | 2. 5 | 3. 6 |
| Female | 2. 9 | 1. 9 | 2. 8 | 2. 8 | 3. 2 | 4. 5 |

Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare.

TABLE 29.—*Percent distribution of visits to physicians offices by seriousness of patient's principal problem, according to patient's sex, color, and age, and region and location of visit: United States, May 1973–April 1974 (from National Ambulatory Medical Care Survey)*

[Percent distribution]

| Sex, color, age, region, and location of visit | Office visits per person per year | Seriousness of patient's principal problem<br>Total | Very serious | Serious | Slightly serious | Not serious |
|---|---|---|---|---|---|---|
| All patients | 3. 1 | 100. 0 | 3. 2 | 16. 0 | 30. 4 | 50. 5 |
| Sex: | | | | | | |
| Male | 2. 5 | 100. 0 | 3. 8 | 18. 1 | 31. 9 | 46. 2 |
| Female | 3. 7 | 100. 0 | 2. 8 | 14. 6 | 29. 4 | 53. 2 |
| Color: | | | | | | |
| White | 3. 2 | 100. 0 | 3. 1 | 15. 7 | 30. 5 | 50. 6 |
| All other | 2. 6 | 100. 0 | 3. 3 | 18. 2 | 29. 5 | 49. 0 |
| Age: | | | | | | |
| Under 15 yr | 2. 3 | 100. 0 | 1. 5 | 10. 2 | 29. 4 | 58. 9 |
| 15 to 24 yr | 2. 6 | 100. 0 | 1. 7 | 10. 7 | 26. 0 | 61. 6 |
| 25 to 44 yr | 3. 2 | 100. 0 | 2. 7 | 14. 0 | 29. 4 | 54. 0 |
| 45 to 64 yr | 3. 8 | 100. 0 | 3. 9 | 20. 1 | 32. 2 | 43. 9 |
| 65 yr and over | 4. 9 | 100. 0 | 6. 3 | 25. 0 | 34. 7 | 33. 9 |
| Region: | | | | | | |
| Northeast | 3. 1 | 100. 0 | 3. 7 | 17. 8 | 28. 7 | 49. 8 |
| North Central | 3. 0 | 100. 0 | 2. 8 | 13. 8 | 31. 6 | 51. 7 |
| South | 3. 1 | 100. 0 | 2. 6 | 13. 8 | 29. 5 | 54. 1 |
| West | 3. 2 | 100. 0 | 4. 0 | 20. 5 | 32. 3 | 43. 2 |
| Location of visit: | | | | | | |
| Metropolitan | 3. 4 | 100. 0 | 3. 4 | 16. 4 | 29. 5 | 50. 7 |
| Nonmetropolitan | 2. 5 | 100. 0 | 2. 5 | 14. 7 | 33. 1 | 49. 7 |

Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare.

TABLE 30.—*Percent of visits to physicians' office's by treatment and services ordered or provided, according to patient's sex, color, and age, and region and location of visit: United States, May 1973–April 1974 (from National Ambulatory Medical Care Survey)*

[Percent of visits with specified treatment or service][1]

| Sex, color, and age, and region and location of visit | Treatments/services ordered or provided | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | None | General history/ exam | Lab procedure/ test | X-rays | Injection/ immunization | Office surgical treatment | Drug therapy[2] | Psychotherapy/ therapeutic listening | Medical counseling/ advice | Other |
| All patients | 5. 3 | 35. 9 | 19. 6 | 7. 1 | 18. 6 | 8. 9 | 49. 4 | 4. 3 | 19. 7 | 8. 8 |
| SEX | | | | | | | | | | |
| Male | 5. 2 | 36. 8 | 16. 0 | 8. 2 | 19. 4 | 11. 0 | 47. 2 | 3. 8 | 19. 1 | 8. 6 |
| Female | 5. 4 | 35. 4 | 22. 0 | 6. 4 | 18. 1 | 7. 6 | 50. 8 | 4. 6 | 20. 1 | 9. 0 |
| COLOR | | | | | | | | | | |
| White | 5. 4 | 35. 8 | 19. 5 | 7. 3 | 18. 5 | 9. 2 | 48. 3 | 4. 5 | 20. 2 | 9. 2 |
| All other | 4. 9 | 37. 1 | 20. 8 | 5. 8 | 19. 5 | 6. 6 | 58. 5 | 2. 6 | 15. 3 | 5. 4 |
| AGE | | | | | | | | | | |
| Under 15 years | 6. 0 | 41. 2 | 13. 0 | 4. 0 | 26. 0 | 7. 8 | 46. 2 | . 8 | 19. 6 | 5. 4 |
| 15 to 24 years | 6. 5 | 35. 6 | 21. 3 | 5. 7 | 14. 0 | 11. 0 | 45. 2 | 3. 1 | 17. 3 | 9. 9 |
| 25 to 44 years | 5. 7 | 33. 8 | 21. 2 | 7. 6 | 14. 1 | 8. 8 | 47. 6 | 8. 0 | 19. 2 | 8. 9 |
| 45 to 64 years | 4. 2 | 34. 6 | 20. 7 | 9. 3 | 19. 6 | 8. 6 | 51. 7 | 5. 0 | 20. 7 | 10. 6 |
| 65 years and over | 4. 6 | 35. 4 | 22. 0 | 8. 0 | 19. 5 | 9. 1 | 56. 9 | 2. 6 | 21. 4 | 8. 9 |
| REGION | | | | | | | | | | |
| Northeast | 4. 0 | 43. 3 | 16. 7 | 6. 9 | 17. 4 | 8. 4 | 50. 0 | 7. 2 | 22. 1 | 10. 0 |
| North-central | 5. 2 | 32. 8 | 18. 2 | 7. 0 | 21. 6 | 8. 6 | 48. 6 | 2. 4 | 18. 3 | 8. 2 |
| South | 6. 1 | 37. 9 | 22. 5 | 6. 4 | 19. 4 | 8. 5 | 51. 4 | 3. 2 | 17. 5 | 7. 6 |
| West | 6. 0 | 27. 5 | 20. 4 | 8. 7 | 14. 2 | 10. 9 | 46. 4 | 5. 0 | 22. 3 | 10. 2 |
| LOCATION OF VISIT | | | | | | | | | | |
| Metropolitan | 4. 9 | 36. 3 | 19. 6 | 7. 8 | 17. 4 | 9. 3 | 48. 5 | 5. 2 | 20. 9 | 9. 4 |
| Nonmetropolitan | 6. 7 | 34. 8 | 19. 6 | 5. 1 | 22. 1 | 7. 8 | 52. 2 | 1. 6 | 16. 1 | 7. 0 |

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[1] Percents will not add to 100 because many patients visits required the provision of more than 1 treatment or service.

[2] Includes prescription and nonprescription drugs.

Source: Health—United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare.

## C. Dental Visits

There were an estimated 342 million dental visits in 1974 or an average of 1.7 visits per person per year. The rate recorded has shown a slight increase since 1972. Females continued to have more visits than males with females seeing a dentist at the rate of 1.8 visits per person per year while the comparable rate for males was 1.5 visits. Rates for both sexes declined after age 65. Approximately 49.3 percent of the population had seen a dentist during the preceding year.

Table 31.—*Dental visits for civilian noninstitutionalized population 1971–74*

| | 1971 | 1972 | 1973 | 1974 |
|---|---|---|---|---|
| Number per person per year | 1. 5 | 1. 5 | 1. 6 | 1. 7 |
| Percent of persons with visits in the past year | 47. 1 | 47. 3 | 48. 9 | 49. 3 |

Source: "Current Estimates From the Health Interview Survey, United States, 1974" U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76–1527, September 1975.

Table 32.—*Number of dental visits and number of dental visits per person per year, by age and sex: United States, 1974*

[Data are based on household interviews of the civilian, noninstitutionalized population]

| Sex | All ages | Under 17 years | 17 to 24 years | 25 to 44 years | 45 to 64 years | 65 years and over |
|---|---|---|---|---|---|---|
| Number of dental visits, both sexes (in thousands): | | | | | | |
| Both sexes | 342, 293 | 100, 999 | 50, 445 | 89, 542 | 76, 687 | 24, 620 |
| Male | 150, 137 | 47, 394 | 20, 284 | 38, 700 | 34, 526 | 9, 233 |
| Female | 192, 156 | 53, 605 | 30, 161 | 50, 842 | 42, 161 | 15, 387 |
| Number of dental visits, both sexes (per person, per year): | | | | | | |
| Both sexes | 1. 7 | 1. 6 | 1. 7 | 1. 7 | 1. 8 | 1. 2 |
| Male | 1. 5 | 1. 5 | 1. 4 | 1. 6 | 1. 7 | 1. 1 |
| Female | 1. 8 | 1. 7 | 2. 0 | 1. 9 | 1. 9 | 1. 3 |

Source: "Current Estimates From the Health Interview Survey, United States, 1974," U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76–1527, September 1975.

TABLE 33.—*Percent distribution of persons by time interval since last dental visit according to sex and age: United States, 1974*

| Sex and age | Total population | Time interval since last dental visit | | | |
|---|---|---|---|---|---|
| | | Under 1 yr | 1 to 4 yrs | 5 yrs and over | Other [1] |
| Both sexes: | | | | | |
| All ages | 100. 0 | 49. 3 | 25. 1 | 13. 8 | 11. 8 |
| Under 17 yrs | 100. 0 | 49. 9 | 16. 7 | 1. 3 | 32. 2 |
| 17 to 24 yrs | 100. 0 | 57. 5 | 31. 5 | 5. 8 | 5. 1 |
| 25 to 44 yrs | 100. 0 | 54. 6 | 30. 9 | 11. 7 | 2. 8 |
| 45 to 64 yrs | 100. 0 | 46. 7 | 27. 6 | 23. 7 | 2. 1 |
| 65 yrs and over | 100. 0 | 28. 6 | 22. 3 | 47. 6 | 1. 6 |
| Male: | | | | | |
| All ages | 100. 0 | 47. 5 | 26. 1 | 13. 7 | 12. 7 |
| Under 17 yrs | 100. 0 | 48. 7 | 17. 2 | 1. 4 | 32. 7 |
| 17 to 24 yrs | 100. 0 | 53. 6 | 34. 2 | 6. 4 | 5. 7 |
| 25 to 44 yrs | 100. 0 | 51. 5 | 32. 2 | 13. 1 | 3. 1 |
| 45 to 64 yrs | 100. 0 | 45. 3 | 28. 2 | 24. 3 | 2. 2 |
| 65 yrs and over | 100. 0 | 26. 9 | 23. 1 | 7. 9 | 2. 0 |
| Female: | | | | | |
| All ages | 100. 0 | 51. 0 | 24. 2 | 13. 9 | 11. 0 |
| Under 17 yrs | 100. 0 | 51. 0 | 16. 1 | 1. 3 | 31. 7 |
| 17 to 24 yrs | 100. 0 | 61. 1 | 29. 1 | 5. 3 | 4. 6 |
| 25 to 44 yrs | 100. 0 | 57. 4 | 29. 6 | 10. 4 | 2. 5 |
| 45 to 64 yrs | 100. 0 | 48. 0 | 27. 0 | 23. 2 | 1. 9 |
| 65 yrs and over | 100. 0 | 29. 6 | 21. 6 | 47. 4 | 1. 4 |

[1] "Other" includes "never" and "unknown."

Note: Numbers may not add due to rounding.

Source: "Current Estimates From the Health Interview Survey, United States, 1974" Department of Health, Education, and Welfare, National Center for Health Statistics, DHEW publication No. (HRA) 76-1527, September 1975.

The number of times an individual sees a dentist during a year differs according to several demographic variables. Whites, females, metropolitan area residents, and those in higher income families average more dental visits per year than their counterparts.

Table 34.—*Number of dental visits per person per year, by age and selected demographic characteristics, 1973*

| | Under age 6 | Ages 6 to 16 | Ages 17 to 44 | Ages 45 to 64 |
|---|---|---|---|---|
| Sex: | | | | |
| Male | | | 1. 4 | 1. 5 |
| Female | | | 1. 9 | 1. 9 |
| Color: | | | | |
| White | 0. 6 | 2. 3 | 1. 8 | 1. 8 |
| Black | . 4 | . 8 | 1. 1 | 1. 0 |
| Region: | | | | |
| Northeast | | 2. 5 | 2. 1 | 2. 2 |
| North Central | | 2. 1 | 1. 7 | 1. 6 |
| South | | 1. 5 | 1. 4 | 1. 4 |
| West | | 2. 7 | 1. 8 | 1. 9 |
| Residence: | | | | |
| Metropolitan | | 2. 3 | 1. 8 | 1. 9 |
| Nonmetropolitan | | 1. 6 | 1. 4 | 1. 4 |
| Family income: | | | | |
| Under $5,000 | NA | 1. 1 | 1. 5 | 1. 2 |
| $5,000 to $9,999 | . 3 | 1. 4 | 1. 4 | 1. 4 |
| $10,000 to $14,999 | . 5 | 2. 2 | 1. 6 | 2. 0 |
| $15,000 or more | 1. 2 | 3. 1 | 2. 1 | 2. 2 |

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

## D. UTILIZATION OF PREVENTIVE CARE SERVICES

Persons living in metropolitan areas are more likely to have had preventive care examinations within the past 2 years than their nonmetropolitan counterparts. High-income persons are more likely to have had preventive health care than the low-income, though even in the highest income categories the lack of basic health care exams is notable for a certain percentage of the population.

Table 35.—*Percent of population with preventive care examination within the past 2 years by selected demographic characteristics: United States, 1973*

| Demographic characteristic | Type of examination | | | | | | |
|---|---|---|---|---|---|---|---|
| | Routine physical, under 17 yr | Eye examination, 3 yr and over | Chest X-ray, 17 yr and over | Pap smear, females 17 yr and over | Breast examination, females 17 yr and over | Electrocardiogram, 40 yr and over | Glaucoma test, 40 yr and over |
| All persons [1] | 62.4 | 56.6 | 43.8 | 57.6 | 59.5 | 33.0 | 33.3 |
| Age: | | | | | | | |
| 3 to 16 yr | 57.7 | 71.3 | ----- | ----- | ----- | ----- | ----- |
| 17 to 24 yr | ----- | 55.9 | 39.1 | 58.1 | 59.9 | ----- | ----- |
| 25 to 44 yr | ----- | 46.2 | 44.7 | 74.7 | 73.7 | ----- | ----- |
| 45 to 64 yr | ----- | 54.5 | 47.2 | 52.0 | 54.8 | 32.7 | 34.8 |
| 65 yr and over | ----- | 48.4 | 41.5 | 30.1 | 36.9 | 37.3 | 34.0 |
| Sex: | | | | | | | |
| Male | 64.6 | 56.3 | 44.5 | ----- | ----- | 36.3 | 31.1 |
| Female | 60.2 | 56.9 | 43.2 | 57.6 | 59.5 | 30.2 | 35.2 |
| Color: | | | | | | | |
| White | 62.7 | 57.0 | 42.4 | 57.8 | 59.8 | 33.1 | 34.0 |
| All other | 61.1 | 53.8 | 54.8 | 56.0 | 57.4 | 31.4 | 27.2 |
| Geographic region: | | | | | | | |
| Northeast | 72.6 | 62.0 | 42.2 | 52.7 | 57.5 | 34.2 | 35.2 |
| North central | 62.3 | 57.1 | 43.5 | 57.9 | 58.0 | 31.1 | 31.5 |
| South | 56.4 | 52.6 | 44.6 | 57.7 | 59.7 | 32.4 | 31.8 |
| West | 60.5 | 55.7 | 45.3 | 63.9 | 64.5 | 35.3 | 36.2 |
| Residence: | | | | | | | |
| Metropolitan | 66.7 | 58.0 | 46.4 | 59.4 | 62.0 | 35.4 | 35.8 |
| Nonmetropolitan | 53.3 | 53.2 | 38.0 | 53.4 | 53.8 | 27.7 | 28.1 |
| Family income: | | | | | | | |
| Under $5,000 | 55.4 | 50.2 | 42.4 | 42.9 | 46.6 | 31.9 | 27.6 |
| $5,000 to $9,999 | 59.0 | 53.8 | 42.4 | 58.1 | 59.3 | 31.1 | 30.9 |
| $10,000 to $14,999 | 63.7 | 58.0 | 43.5 | 64.9 | 65.6 | 31.0 | 33.6 |
| $15,000 and over | 69.0 | 63.0 | 47.6 | 66.2 | 68.7 | 37.9 | 42.0 |

[1] Includes unknown income.

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare.

An important component of preventive health care is the administration of certain vaccines during the early years of life. However, a significant percentage of children are not adequately protected. Of particular significance is the decline in the percentage of persons protected against polio. Less than half of the minority children under age 5 have received the necessary vaccines. While the number of persons with rubella vaccine has increased from 1970 to 1974, less than two-thirds of children aged 1–4 have been vaccinated to prevent the spread of the disease. The percent of persons with protection against measles and diptheria-typhoid-pertussis has remained relatively constant over the past 5 years.

TABLE 36.—*Percent of persons with 3 or more doses of polio vaccine by race and age, 1965–74, and by geographic division and age, 1974: United States*

| Year and race | Age in years— | | | |
|---|---|---|---|---|
| | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 19 |
| 1965: | | | | |
| Total | 73.9 | 89.9 | 92.1 | 88.3 |
| White | 76.6 | 91.4 | 93.1 | 89.2 |
| All other | 59.6 | 81.3 | 85.9 | 82.1 |
| 1966: | | | | |
| Total | 70.2 | 88.2 | 90.0 | 86.4 |
| White | 72.9 | 89.6 | 90.9 | 87.4 |
| All other | 56.6 | 79.8 | 85.0 | 79.1 |
| 1967: | | | | |
| Total | 70.9 | 88.3 | 89.7 | 82.5 |
| White | 73.1 | 89.8 | 90.7 | 83.5 |
| All other | 60.2 | 80.5 | 83.5 | 75.5 |
| 1968: | | | | |
| Total | 68.3 | 84.9 | 87.8 | 81.3 |
| White | 71.0 | 86.3 | 89.2 | 82.5 |
| All other | 54.5 | 77.0 | 79.3 | 73.2 |
| 1969: | | | | |
| Total | 67.7 | 83.6 | 85.7 | 79.8 |
| White | 70.7 | 85.4 | 87.7 | 81.4 |
| All other | 53.6 | 73.6 | 74.8 | 69.6 |
| 1970: | | | | |
| Total | 65.9 | 82.3 | 85.3 | 77.8 |
| White | 69.2 | 83.8 | 86.6 | 79.5 |
| All other | 50.1 | 74.8 | 76.7 | 67.7 |
| 1971: | | | | |
| Total | 67.3 | 81.2 | 83.9 | 77.0 |
| White | 70.5 | 82.8 | 85.9 | 79.0 |
| All other | 51.9 | 72.9 | 71.9 | 65.0 |
| 1972: | | | | |
| Total | 62.9 | 78.9 | 81.8 | 75.4 |
| White | 66.3 | 81.6 | 83.7 | 77.3 |
| All other | 45.2 | 64.7 | 71.5 | 63.7 |
| 1973: | | | | |
| Total | 60.4 | 71.4 | 69.3 | 59.1 |
| White | 64.4 | 73.5 | 71.1 | 61.0 |
| All other | 39.8 | 60.3 | 59.0 | 47.8 |
| 1974: | | | | |
| Total | 63.1 | 73.5 | 69.8 | 60.2 |
| White | 66.7 | 76.0 | 71.8 | 62.1 |
| All other | 45.0 | 60.4 | 59.1 | 49.3 |
| 1974—Geographic divisions: | | | | |
| New England | 71.4 | 79.6 | 73.4 | 59.6 |
| Middle Atlantic | 64.1 | 71.8 | 67.7 | 56.0 |
| East north central | 59.0 | 66.2 | 61.6 | 53.2 |
| West north central | 61.4 | 71.9 | 66.0 | 57.3 |
| South Atlantic | 63.1 | 74.5 | 70.7 | 59.9 |
| East south central | 57.9 | 73.4 | 70.9 | 66.1 |
| West south central | 67.3 | 81.1 | 79.7 | 71.6 |
| Mountain | 62.9 | 75.1 | 71.9 | 68.5 |
| Pacific | 63.9 | 77.2 | 76.3 | 64.1 |

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

TABLE 37.—*Percent of persons with history of rubella vaccine by race and age, 1970–74, and by geographic division and age, 1974: United States*

| Year and race | Age in years— 1 to 4 | 5 to 9 | 10 to 12 |
|---|---|---|---|
| 1970: | | | |
| Total | 37. 2 | 46. 5 | 29. 5 |
| White | 38. 3 | 47. 4 | 29. 0 |
| All other | 31. 8 | 41. 7 | 32. 0 |
| 1971: | | | |
| Total | 51. 2 | 63. 2 | 47. 3 |
| White | 51. 8 | 63. 5 | 46. 7 |
| All other | 48. 2 | 61. 6 | 51. 2 |
| 1972: | | | |
| Total | 56. 9 | 66. 8 | 55. 2 |
| White | 57. 8 | 67. 4 | 54. 8 |
| All other | 52. 6 | 63. 7 | 57. 7 |
| 1973: | | | |
| Total | 55. 6 | 64. 9 | 54. 1 |
| White | 57. 0 | 65. 8 | 54. 0 |
| All other | 48. 5 | 59. 8 | 54. 2 |
| 1974: | | | |
| Total | 59. 8 | 68. 0 | 57. 5 |
| White | 61. 0 | 69. 0 | 57. 9 |
| All other | 53. 6 | 62. 9 | 55. 2 |
| 1974—Geographic division: | | | |
| New England | 57. 1 | 66. 8 | 53. 7 |
| Middle Atlantic | 66. 5 | 73. 5 | 63. 2 |
| East north central | 59. 9 | 67. 7 | 57. 5 |
| West north central | 58. 2 | 73. 9 | 63. 5 |
| South Atlantic | 59. 7 | 70. 2 | 57. 2 |
| East south central | 55. 9 | 61. 4 | 50. 8 |
| West south central | 58. 3 | 67. 9 | 60. 0 |
| Mountain | 52. 8 | 61. 6 | 56. 6 |
| Pacific | 59. 0 | 61. 6 | 50. 3 |

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

TABLE 38.—*Percent of persons with history of measles vaccine and/or measles infection by race and age, 1974, United States*

| Year and race | Age in years 1 to 4 | 5 to 9 | 10 to 13 |
|---|---|---|---|
| 1974: | | | |
| Total | 66. 6 | 80. 8 | 81. 1 |
| White | 68. 6 | 82. 4 | 83. 2 |
| All other | 56. 3 | 72. 4 | 69. 4 |

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

TABLE 39.—*Percent of persons with 3 or more doses of diphtheria-typhoid-pertussis vaccine by race and age, 1974: United States*

| Year and race | Age in years— 1 to 4 | 5 to 9 | 10 to 13 |
|---|---|---|---|
| 1974: | | | |
| Total | 73. 9 | 84. 7 | 85. 5 |
| White | 76. 8 | 86. 7 | 87. 5 |
| All other | 59. 6 | 74. 2 | 74. 8 |

## E. UTILIZATION OF MENTAL HEALTH CARE AND MENTAL RETARDATION FACILITIES

Both the number and the rate of patient care episodes in mental health facilities more than doubled between 1955 and 1973. A significant decline occurred in the proportion of inpatient episodes (from 77.4 percent of 35.3 percent of the total) with a comparable increase in the percentage of outpatient episodes (22.6 percent to 63.7 percent). The rates of inpatient care episodes reached their peak in 1969; outpatient rates showed a steady increase over the period. There were 2.5 million admissions to psychiatric services in 1971—1.2 million to inpatient and 1.3 million to outpatient services. Females had higher outpatient than inpatient rates while the reverse was true for males.

TABLE 40.—*Number, percent distribution, and rates per 100,000 population of inpatient and outpatient care episodes, in selected mental health facilities, by type of facility: United States 1955, 1965, 1967, 1969, 1971, and 1973* [1]

| Year | Total facilities [1] | | Total inpatient | Inpatient services of— | | | | | Total out-patient | Outpatient psychiatric services of— | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | State and county mental hospitals | Private mental hospitals [2] | General hospital psychiatric service (non-VA) | VA psychiatric inpatient services | Federally assisted community mental health centers | | Federally assisted community mental health centers | Other |
| Percent distribution: | | | | | | | | | | | |
| 1973 | 4, 749, 361 | 100. 0 | 35. 3 | 13. 7 | 3. 2 | 10. 0 | 4. 4 | 4. 0 | 64. 7 | 20. 7 | 44. 0 |
| 1971 | 4, 038, 143 | 100. 0 | 42. 6 | 18. 5 | 3. 1 | 13. 4 | 4. 4 | 3. 2 | 57. 4 | 15. 4 | 42. 0 |
| 1969 | 3, 572, 822 | 100. 0 | 47. 0 | 21. 5 | 3. 5 | 15. 0 | 5. 2 | 1. 8 | 53. 0 | 8. 1 | 44. 9 |
| 1967 | 3, 139, 742 | 100. 0 | 52. 9 | 25. 5 | 4. 0 | 18. 4 | 4. 1 | . 9 | 47. 1 | 3. 1 | 44. 0 |
| 1965 | 2, 636, 525 | 100. 0 | 59. 4 | 30. 5 | 4. 8 | 19. 7 | 4. 4 | ---------- | 40. 6 | ---------- | 40. 6 |
| 1955 | 1, 675, 352 | 100. 0 | 77. 4 | 48. 9 | 7. 3 | 15. 9 | 5. 3 | ---------- | 22. 6 | ---------- | 22. 6 |
| Rate per 100,000 population: | | | | | | | | | | | |
| 1973 | | 2, 282. 4 | 807. 2 | 313. 3 | 73. 0 | 228. 5 | 100. 2 | 92. 2 | 1, 475. 2 | 472. 2 | 1, 003. 0 |
| 1971 | | 1, 981. 5 | 847. 2 | 364. 9 | 66. 1 | 265. 7 | 86. 9 | 63. 7 | 1, 134. 3 | 305. 0 | 829. 3 |
| 1969 | | 1, 797. 7 | 849. 6 | 384. 2 | 62. 0 | 268. 2 | 93. 6 | 41. 7 | 948. 1 | 145. 2 | 802. 9 |
| 1967 | | 1, 604. 3 | 847. 9 | 409. 5 | 63. 5 | 295. 6 | 65. 5 | 13. 8 | 756. 4 | 49. 7 | 706. 7 |
| 1965 | | 1, 374. 0 | 815. 9 | 419. 5 | 65. 4 | 270. 6 | 60. 4 | ---------- | 558. 1 | ---------- | 558. 1 |
| 1955 | | 1, 032. 2 | 798. 6 | 504. 5 | 75. 9 | 163. 8 | 54. 4 | ---------- | 233. 5 | ---------- | 233. 5 |

[1] Omitted from this table are: private psychiatric office practice; psychiatric service modes of all types in hospitals or outpatient clinics of Federal agencies other than the VA (e.g., Public Health Service, Indian Health Service, Department of Defense, Bureau of Prisons, etc.); inpatient service modes of multiservice facilities not shown in this table; all partial care episodes, and outpatient episodes in VA hospitals.

[2] Includes estimates of episodes of care in residential treatment centers for emotionally disturbed children.

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare.

TABLE 41.—*Admission rates per 100,000 population to psychiatric inpatient and outpatient services by color and sex, by sex and age, and by diagnosis: United States, 1971*

[Rates per 100,000 population]

| Color sex, age, and diagnosis | All inpatient and outpatient services | Inpatient[1] | Outpatient[2] |
|---|---|---|---|
| Color and sex: | | | |
| Both sexes | 1, 238. 5 | 596. 7 | 641. 8 |
| Male | 1, 319. 1 | 658. 9 | 633. 2 |
| Female | 1, 162. 2 | 512. 3 | 649. 9 |
| White | 1, 173. 2 | 566. 8 | 606. 4 |
| Male | 1, 241. 4 | 642. 1 | 599. 4 |
| Female | 1, 108. 3 | 495. 4 | 613. 0 |
| All other | 1, 696. 2 | 806. 1 | 890. 0 |
| Male | 1, 871. 4 | 998. 0 | 873. 4 |
| Female | 1, 534. 4 | 629. 1 | 905. 3 |
| Sex and age: | | | |
| Both sexes | 1, 238. 5 | 596. 7 | 641. 8 |
| Under 18 yr | 626. 8 | 123. 8 | 503. 1 |
| 18 to 25 yr | 1, 936. 0 | 879. 8 | 1, 056. 1 |
| 25 to 44 yr | 1, 982. 2 | 1, 017. 3 | 964. 8 |
| 45 to 64 yr | 1, 315. 7 | 811. 5 | 504. 2 |
| 65 yr and over | 615. 2 | 464. 1 | 151. 0 |
| Male | 1, 319. 1 | 685. 9 | 633. 2 |
| Under 18 yr | 736. 4 | 127. 7 | 608. 8 |
| 18 to 24 yr | 2, 264. 9 | 1, 167. 5 | 1, 097. 5 |
| 25 to 44 yr | 1, 914. 2 | 1, 121. 9 | 792. 2 |
| 45 to 64 yr | 1, 403. 8 | 962. 2 | 441. 6 |
| 65 yr and over | 658. 6 | 535. 5 | 123. 1 |
| Female | 1, 162. 2 | 512. 3 | 649. 9 |
| Under 18 yr | 513. 1 | 119. 7 | 393. 4 |
| 18 to 24 yr | 1, 634. 9 | 616. 6 | 1, 018. 3 |
| 25 to 44 yr | 2, 047. 8 | 916. 4 | 1, 131. 5 |
| 45 to 64 yr | 1, 235. 2 | 673. 9 | 561. 4 |
| 65 yr and over | 583. 5 | 412. 1 | 171. 4 |
| Diagnosis: | | | |
| All diagnoses | 1, 238. 5 | 596. 7 | 641. 8 |
| Mental retardation | 28. 9 | 7. 4 | 21. 5 |
| Organic brain syndromes | 54. 9 | 37. 6 | 17. 3 |
| Schizophrenia | 258. 0 | 161. 1 | 96. 9 |
| Depressive disorders | 216. 9 | 134. 3 | 82. 6 |
| Other psychotic disorders | 18. 9 | 9. 8 | 9. 1 |
| Alcoholism | 127. 9 | 94. 0 | 33. 9 |
| Drug abuse | 43. 1 | 30. 2 | 12. 9 |
| All other disorders | 401. 1 | 110. 9 | 290. 2 |
| Undiagnosed | 88. 9 | 11. 5 | 77. 4 |

[1] Excludes residential treatment centers for emotionally disturbed children and other multiservice facilities for which the demographic characteristics of admissions were not available.

[2] Excludes VA hospitals and residential treatment centers for emotionally disturbed children for which the demographic characteristics of admissions were not available.

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare.

In 1971, there were approximately 201,225 patients treated in public institutions for the mentally retarded. The average daily resident caseload was approximately 181,000. Total admissions during the year were 15,370 and net live releases were 17,080.

## F. LONG-TERM CARE UTILIZATION

The term nursing home embraces a wide variety of health care facilities from special long-term hospitals providing intensive medical care services to the boarding home providing only the simplest form of supporting services. The term "extended care facilities" (ECF's) was the term initially used by the medicare program for approved facilities providing posthospital nursing care to program beneficiaries. The medicaid program used the term "skilled nursing homes" (SNH's) to designate those approved homes providing skilled nursing care to medicaid recipients. In 1972, ECF's and SNH's were redesignated as "skilled nursing facilities" (SNF's); uniform certification procedures and definition of care were established for both programs. An additional category of nursing home care receiving Federal support is "intermediate care" provided by "intermediate care facilities" (ICF's); such facilities, certified to participate in the medicaid program (but not the medicare program) provide a lesser level of health-related care than do SNF's to patients requiring institutional care above the level of room and board.

There were approximately 1.1 million resident patients in all categories of nursing homes in 1973. Over two-thirds of this population, 70.2 percent, were female. Fifty percent of all nursing home residents received care financed by medicaid (29 percent received SNF care and 21 percent intermediate care) while only 4 percent received care financed by medicare. Measures of utilization for 1972 showed the number of admissions per bed per year was 0.86. Homes certified by both medicare and medicaid had the highest turnover rate and the highest percentage of residents discharged alive. The high turnover rate was attributable to two factors. First, since medicare coverage for SNF care is available only following a hospital stay, many of the residents were recovering from an operation or illness and discharged upon recovery. Secondly, medicare will only pay up to 100 days of skilled care in a medicare-approved home.

The following tables show the major utilization characteristics of U.S. nursing homes. The data are provisional estimates developed by the National Center for Health Statistics from the 1973–74 Nursing Home Survey.

TABLE 42.—*Provisional estimates of selected characteristics of nursing home beds certified for medicare or medicaid: United States, 1973–74*

[Figures may not add to totals due to rounding]

| Certification status of bed | Beds[1] |  | Beds occupied by resident receiving program benefits |  | Percent of total residents receiving program benefits |
|---|---|---|---|---|---|
|  | Number | Percent of total beds | Number of beds | Percent occupied night before interview |  |
| ECF beds (medicare) | 287, 400 | 24. 2 | 45, 200 | 15. 7 | 4. 1 |
| SNH beds (medicaid) | 538, 900 | 45. 4 | 321, 100 | 59. 6 | 29. 2 |
| ICF beds (medicaid) | 378, 600 | 31. 9 | 229, 900 | 60. 7 | 20. 9 |

[1] These figures are not mutually exclusive because some beds have dual certification. For example, a bed certified for medicare may also be certified by medicaid. Since 1 bed may be counted twice, the sum of all certified beds exceeds the actual number of beds (1,188,000). For the same reason, the percent distribution exceeds 100 percent.

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare, 1975.

TABLE 43.—*Provisional number and percent of nursing home residents for 1973–74, and provisional estimates of selected measures of utilization for 1972, by certification status: United States*

[Figures may not add to totals due to rounding]

| Certification status of home | Residents in 1973–74 |  |  |  | Measures of utilization for 1972 |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|
|  |  | Percent |  |  |  |  |  | Discharges |  |  |  |
|  |  |  |  |  |  |  |  |  | Percent |  |  |
|  | Number | Both sexes | Male | Female | Ad-missions | Number of ad-missions per bed | Annual occu-pancy rate [1] | Number | Total | Live | Dead |
| All types of certification | 1, 098, 500 | 100 | 29. 8 | 70. 2 | 1, 018, 300 | 0. 86 | 88. 6 | 984, 600 | 100 | 69. 3 | 30. 7 |
| Both medicare and medicaid [2] | 393, 600 | 100 | 28. 5 | 71. 5 | 549, 400 | 1. 27 | 83. 6 | 535, 400 | 100 | 73. 0 | 27. 0 |
| Medicaid only | 524, 800 | 100 | 31. 0 | 69. 0 | 362, 300 | . 64 | 90. 4 | 342, 700 | 100 | 65. 8 | 34. 2 |
| SNH [3] | 278, 600 | 100 | 30. 3 | 69. 7 | 209, 700 | . 71 | 91. 0 | 194, 500 | 100 | 67. 8 | 32. 2 |
| ICF | 246, 200 | 100 | 31. 8 | 68. 2 | 152, 600 | . 57 | 89. 7 | 148, 200 | 100 | 63. 2 | 36. 8 |
| Not certified | 180, 100 | 100 | 29. 4 | 70. 6 | 106, 700 | . 55 | 94. 6 | 106, 500 | 100 | 61. 8 | 38. 3 |

[1] $\frac{\text{Aggregate number of days of care provided to residents in 1972}}{\text{Number of beds}} \times 366 \times 100$

[2] 12 percent of these homes were certified by medicare only.

[3] 46 percent of these homes were also certified as ICF's.

In 1974, the Office of Nursing Home Affairs conducted a scientifically selected sample survey of skilled nursing facilities and their residents for the purpose of developing a national profile. The sample survey included 288 facilities certified for participation in medicare and 283,915 medicare and medicaid beneficiaries in those homes. The demographic characteristics and health status of these patients is considered fairly representative of the nationwide population of medicare and medicaid residents in such facilities. The survey did not include ICF's where a larger number of mentally retarded and developmentally disabled are found.

Approximately 78 percent of the SNF patients surveyed were over 65 year of age and almost 50 percent were 80 years or over. Women outnumbered men by more than 2 to 1; only 27.1 percent were male compared with 72.9 percent female. Slightly less than 10 percent of the patients represented minority groups with the largest proportion—7 percent—of the black race. Less than one out of every eight patients was married at the time of the survey with the largest proportion, 60.6 percent, widowed (51.4 percent widows and 9.2 percent widowers). About 30 percent of all patients had less than 8 years of schooling while an additional 22.1 percent had only completed 8 years. Less than 9 percent of all patients had ever attended college. The educational levels were in turn reflected in the patients' occupational patterns with only 7.6 percent having been employed as professional workers. Almost one-third had been employed as farmers, skilled service or clerical workers, with an additional one-fifth employed as unskilled laborers. More than one-fourth had been homemakers and over 13 percent had never been employed. Very few patients in SNF's were currently in the labor force. While close to 70 percent were participants at one time, 64 percent were retired. Over 95 percent were not employed and not seeking employment. Patient and family incomes of SNF residents was very limited. Over 68 percent of all family income was less than $3,000 with an additional 22 percent having no income. This indicates that over 90 percent were below the poverty level. Tables 44–46 highlight the major characteristics of medicare and medicaid SNF patients reported in the survey.

**Table 44.**—*Number and percent distribution of survey patients in skilled nursing facilities by age*

| Age group(s) | Number | Percent |
|---|---|---|
| Total | 283,915 | 100. 0 |
| Under 20 | 4,838 | 1. 7 |
| 20 to 64 | 58,048 | 20. 4 |
| 65 to 69 | 15,139 | 5. 3 |
| 70 to 74 | 28,384 | 10. 0 |
| 75 to 79 | 35,954 | 12. 7 |
| 80 to 84 | 52,984 | 18. 7 |
| 85 to 89 | 56,769 | 20. 0 |
| 90 and over | 31,799 | 11. 2 |

Source: U.S. Dept. of Health, Education, and Welfare, Public Health Service, Office of Nursing Home Affairs. Long Term Care Facility Improvement Study—Introductory Report. July, 1975.

TABLE 45.—*Number and percent of survey patients by sex and race*

| Race(s) | Both sexes total | | Male total | | Female total | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| All races | 283,912 | 100. 0 | 76,845 | 27. 1 | 207,067 | 73. 0 |
| White | 256,827 | 90. 5 | 66,691 | 23. 5 | 190,136 | 67. 0 |
| Negro/black | 19,952 | 7. 0 | 7,417 | 2. 6 | 12,535 | 4. 4 |
| Spanish American | 4,419 | 1. 6 | 1,899 | . 7 | 2,520 | . 9 |
| Asian American | 940 | . 3 | 120 | . 0 | 820 | . 3 |
| Other | 1,774 | . 6 | 718 | . 3 | 1,056 | . 4 |

NOTE: Uniform procedures were used in computations; there may be a minor difference between the sum total figure and the total obtained when the subtotals are added together.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Office of Nursing Home Affairs. Long Term Care Facility Improvement Study—Introductory Report. July 1975.

TABLE 46.—*Number and percent of survey patients by sex and family income*

| Family income totals | Both sexes | | Male sex | | Female sex | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| All incomes | 283, 917 | 100. 0 | 78, 186 | 27. 6 | 205, 731 | 72. 4 |
| $15,000 or more | 2, 075 | . 7 | 1, 437 | . 5 | 588 | . 2 |
| $10,000 to $14,999 | 1, 132 | . 4 | 254 | . 1 | 878 | . 3 |
| $7,000 to $9,999 | 1, 754 | . 6 | 522 | . 2 | 1, 232 | . 4 |
| $5,000 to $6,999 | 4, 962 | 1. 7 | 2, 009 | . 7 | 2, 953 | 1. 0 |
| $3,000 to $4,999 | 15, 107 | 5. 4 | 6, 141 | 2. 2 | 8, 966 | 3. 2 |
| Less than $3,000 | 194, 949 | 68. 7 | 46, 417 | 16. 4 | 148, 532 | 52. 3 |
| No income | 63, 988 | 22. 5 | 21, 406 | 7. 5 | 42, 582 | 15. 0 |

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Office of Nursing Home Affairs. Long Term Care Facility Improvements Study—Introductory Report. July 1975.

The HEW sample survey also examined the health status of the sample population group. An assessment of the patient needs for care showed the high degree of dependence on the nursing staff for activities of daily living. Almost 94 percent required assistance with bathing; 72 percent required the services of another person when dressing; 50.1 percent required assistance in order to eat; and 68 percent needed assistance with their toileting. Approximately half of all patients were incontinent of either urine (54.7 percent) or feces (50.1 percent). Long-term patients with limited mobility are prone to have pressure sores; however, only 9.2 percent were found to have bedsores.

The effects of developmental disabilities, chronic illness, and aging on mental functions are complex and have a wide variation among individuals. In response to simple questions, over half of all patients showed some degree of difficulty in their awareness of the existing situation with reference to time, place, and identity of self. One-seventh of the patients had no awareness of their environment at any time or were comatose. Appropriateness of patients' behavior patterns with respect to the nursing home environment was also examined. Behavior was suitable to the environment for 58.4 percent while 41.1 percent had inappropriate behavior. In this latter group patients were about equally divided between those who were passive, those who were disruptive, and those with other detrimental behavior. Most patients in the survey were able to communicate their needs either verbally (74.5 percent) or nonverbally (6.9 percent).

The majority of the surveyed patients (70.4 percent) had sight impairments including 2.6 percent who were legally blind and 52.7 percent who wore corrective lenses or glasses. Hearing impairments occurred in 32.9 percent of the patients; 32 percent had speech difficulties. Observations on the dental status showed only 8.1 percent with no missing teeth. A significant percentage, 38.1 percent, required teeth replaced, including full dentures, but had none.

Age was an important factor in the diagnostic profile of the SNF patients. The primary diagnoses for two-thirds of those under age 65 was pathology of the nervous system—neurological disease, mental retardation, neuroses and psychoses, stroke, and chronic brain disease. Alternatively, for two-thirds of the aged, primary diagnoses were cardiovascular and cerebrovascular disease, senility, and accidents. Age differentials were also reflected in the total diagnostic profile. For the younger population group, 42 percent had an identified neurological disease; 26.8 percent were mentally retarded: and 20.5 percent had a neuroses or psychoses. For the aged, 43.1 percent had heart disease, 32.7 percent chronic brain disease, 24.9 percent generalized arteriosclerosis or hypertension, 21.4 percent arthritis, and 19.1 percent stroke. Of the total postadmission diagnoses recorded, one in three for the aged and two out of five for those under 65 generally related to institutionalization and prolonged bed rest. Tables 47–49 provide a diagnostic profile of the survey population.

TABLE 47.—*Primary diagnoses of survey population recorded on admission by diagnostic group and by age*

| Diagnoses | All ages | | Under 65 | | 65 and over | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Total | 283, 300 | 100. 0 | 50, 400 | 100. 0 | 232, 900 | 100. 0 |
| Heart disease | 44, 300 | 15. 6 | 2, 500 | 5. 0 | 41, 900 | 18. 0 |
| Chronic brain disease | 39, 200 | 13. 8 | 3, 700 | 7. 3 | 35, 500 | 15. 2 |
| Stroke | 30, 300 | 10. 7 | 3, 900 | 7. 7 | 26, 400 | 11. 3 |
| Fractures | 24, 800 | 8. 8 | 1, 700 | 3. 4 | 23, 100 | 9. 9 |
| Neurological disease | 19, 000 | 6. 7 | 9, 600 | 19. 0 | 9, 500 | 4. 1 |
| Generalized arteriosclerosis and hypertension | 17, 300 | 6. 1 | 1, 300 | 2. 6 | 16, 000 | 6. 9 |
| Neuroses and psychoses | 15, 200 | 5. 4 | 5, 700 | 11. 3 | 9, 500 | 4. 1 |
| Diabetes | 14, 300 | 5. 0 | 1, 700 | 3. 4 | 12, 600 | 5. 4 |
| Diseases of musculoskeletal system | 13, 400 | 4. 7 | 2, 000 | 4. 0 | 11, 300 | 4. 9 |
| Mental retardation | 9, 300 | 3. 3 | 9, 000 | 17. 9 | 400 | . 2 |
| Neoplasms | 8, 400 | 3. 0 | 1, 800 | 3. 6 | 6, 600 | 2. 8 |
| Diseases of respiratory system | 6, 600 | 2. 3 | 800 | 1. 6 | 5, 700 | 2. 4 |
| Diseases of digestive system | 6, 500 | 2. 3 | 600 | 1. 1 | 6, 000 | 2. 6 |
| Diseases of genito-urinary system | 3, 700 | 1. 3 | 500 | 1. 0 | 3, 200 | 1. 3 |
| Diseases of eye and ear | 3, 300 | 1. 2 | 600 | 1. 1 | 2, 700 | 1. 2 |
| Other | 27, 700 | 9. 8 | 5, 000 | 10. 0 | 22, 700 | 9. 7 |

Source: U.S. Department of Health, Education, and Welfare. Public Health Service, Office of Nursing Home Affairs. Long-Term Facility Improvement Study—Introductory report. July 1975.

TABLE 48.—*All diagnoses of survey population recorded on admission by diagnostic group and by age*

| Diagnoses | All ages | | Under 65 | | 65 and over | |
|---|---|---|---|---|---|---|
| | Number | Percent [1] | Number | Percent [2] | Number | Percent [3] |
| Heart disease | 108, 200 | 38. 1 | 7, 800 | 15. 2 | 100, 400 | 43. 1 |
| Chronic brain disease | 83, 000 | 29. 2 | 6, 900 | 13. 5 | 76, 100 | 32. 7 |
| Generalized arteriosclerosis and hypertension | 64, 800 | 22. 8 | 6, 800 | 13. 3 | 57, 900 | 24. 9 |
| Diseases of musculoskeletal system | 55, 800 | 19. 7 | 6, 100 | 11. 9 | 49, 700 | 21. 4 |
| Stroke | 51, 300 | 18. 1 | 6, 900 | 13. 5 | 44, 400 | 19. 1 |
| Fractures | 46, 200 | 16. 3 | 4, 400 | 8. 6 | 41, 800 | 18. 0 |
| Neurological disease | 43, 800 | 15. 4 | 21, 500 | 42. 0 | 22, 300 | 9. 6 |
| Diabetes | 40, 700 | 14. 3 | 6, 100 | 11. 9 | 34, 600 | 14. 9 |
| Neuroses and psychoses | 34, 100 | 12. 0 | 10, 500 | 20. 5 | 23, 600 | 10. 1 |
| Diseases of digestive system | 30, 700 | 10. 8 | 4, 000 | 7. 8 | 26, 700 | 11. 5 |
| Diseases of genito-urinary system | 29, 600 | 10. 3 | 5, 500 | 10. 7 | 24, 100 | 10. 4 |
| Diseases of eye and ear | 28, 400 | 10. 0 | 5, 900 | 11. 5 | 22, 500 | 9. 7 |
| Diseases of respiratory system | 21, 400 | 7. 5 | 3, 400 | 6. 6 | 18, 000 | 7. 7 |
| Neoplasms | 15, 800 | 5. 6 | 3, 300 | 6. 4 | 12, 500 | 5. 4 |
| Mental retardation | 14, 900 | 5. 2 | 13, 700 | 26. 8 | 1, 200 | (4) |
| Other [5] | 52, 700 | 18. 6 | 11, 600 | 22. 7 | 41, 100 | 17. 7 |

[1] Percentages are based on a total of 283,900 patients.

[2] Percentages are based on a total of 51,200 patients.

[3] Percentages are based on a total of 232,700 patients.

[4] Less than 0.1 percent.

[5] Includes major surgery, endocrine disease (other than diabetes mellitus), anemias, nutritional disease, and decubitus ulcers and other skin disorders.

Note: Percentages add up to more than 100 because of multiple diagnoses recorded on admission for same patients.

Source: U.S. Department of Health, Education, and Welfare. Public Health Service, Office of Nursing Home Affairs. Long-Term Facility Improvement Study—Introductory Report. July 1975.

TABLE 49.—*Rank order of most common diagnostic groups of survey population by time of recording and age group*

| Rank order | Primary diagnoses on admission | | All diagnoses on admission | | All diagnoses postadmission | |
|---|---|---|---|---|---|---|
| | Under 65 | 65 and over | Under 65 | 65 and over | Under 65 | 65 and over |
| 1 | Neurological disease | Heart disease | Neurological disease | Heart disease | Diseases of respiratory system. | Diseases of genito-urinary system. |
| 2 | Mental retardation | Chronic brain disease | Mental retardation | Chronic brain disease | Decubitus ulcers and other skin diseases. | Diseases of eye and ear. |
| 3 | Neuroses and psychoses | Stroke | Neuroses and psychoses. | General arteriosclerosis and hypertension. | Diseases of digestive system. | Decubitus ulcers and other skin diseases. |
| 4 | Stroke | Fractures | Heart disease | Diseases of musculo-skeletal system. | Diseases of genito-urinary system. | Diseases of musculo-skeletal system. |
| 5 | Chronic brain disease | General arteriosclerosis and hypertension. | Chronic brain disease | Stroke | Diseases of eye and ear | Heart disease. |
| 6 | Heart disease | Diabetes | Stroke | Fractures | Fractures | Fractures. |
| 7 | Diseases of musculo-skeletal system. | Diseases of musculo-skeletal system. | General arteriosclerosis and hypertension. | Diabetes | Heart disease | Diseases of digestive system. |
| 8 | Neoplasms | Neuroses and psychoses. | Diseases of musculo-skeletal system. | Diseases of digestive system. | Diseases of musculo-skeletal system. | Diseases of respiratory system. |
| 9 | Diabetes | Neurological disease | Diabetes | Diseases of genito-urinary system. | | |
| 10 | Fractures | Neoplasms | Diseases of eye and ear | Neuroses and psychoses. | | |

Source: U.S. Department of Health, Education, and Welfare. Public Health Service, Office of Nursing Home Affairs. Long-term Facility Improvement Study—Introductory Report. July 1975.

Sixty percent of the survey residents had been examined by a physician within a month prior to the survey, and an additional 17 percent between 1–2 months prior to the survey. Nine percent of the patients who had been in the homes in excess of a year had not been examined by a physician for at least a year.

Approximately 41 percent of the nursing home patients receive intensive care, 32 percent routine nursing care, and 16 percent personal nursing care.

TABLE 50.—*Numbers and percent distribution of nursing home residents by length of time since current admission according to interval since last saw physician: United States, 1973–74*

| Interval since last saw physician | All residents | Length of stay since current admission | | | | |
|---|---|---|---|---|---|---|
| | | Under 6 mo | 6 mo to 1 yr | 1 to 3 yr | 3 to 5 yr | 5 yr or more |
| Number of residents | 1,074,500 | 258,800 | 155,500 | 357,200 | 149,600 | 153,400 |
| Percent distribution: | | | | | | |
| All intervals | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Less than 1 mo | 60.1 | 70.6 | 63.1 | 56.8 | 55.1 | 52.1 |
| 1 to 2 mo | 16.8 | 13.8 | 17.3 | 17.8 | 18.4 | 17.4 |
| 3 to 5 mo | 11.9 | 6.2 | 12.8 | 12.9 | 14.2 | 15.8 |
| 6 mo to 1 yr | 3.2 | --------- | 4.7 | 3.9 | 3.6 | 5.2 |
| 1 yr or more | 4.7 | --------- | --------- | 7.3 | 7.5 | 8.3 |
| Not since admission | 3.4 | 9.3 | 2.2 | 1.4 | 1.3 | 1.2 |

Source: Health: United States, 1975 Public Health Service U.S. Department of Health, 1975.

TABLE 51.—*Number and percent distribution of nursing home residents by age and sex according to level of nursing care received: United States, 1973–74*

| Level of nursing care received [1] | All residents | Age | | | | Sex | |
|---|---|---|---|---|---|---|---|
| | | Under 65 yr | 65 to 74 yr | 75 to 84 yr | 85 yr and over | Male | Female |
| Number of residents | 1, 074, 500 | 114, 200 | 162, 900 | 384, 400 | 413, 000 | 317, 800 | 756, 600 |
| Percent distribution: | | | | | | | |
| All levels | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 | 100. 0 |
| Intensive nursing care | 41. 0 | 35. 5 | 37. 0 | 41. 1 | 44. 1 | 37. 6 | 42. 5 |
| Limited nursing care | 9. 8 | 9 5 | 11. 0 | 10. 2 | 9. 1 | 10. 1 | 9. 7 |
| Routine nursing care | 32. 3 | 30. 0 | 33. 8 | 33. 2 | 31. 5 | 33. 6 | 31. 7 |
| Personal nursing care | 16. 0 | 24. 1 | 17. 1 | 14. 5 | 14. 7 | 17. 5 | 15. 4 |
| No nursing care | . 9 | ------ | 1. 0 | 1. 0 | . 6 | 1. 1 | . 8 |

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[1] Intensive nursing care includes: full bed bath, catheterization, oxygen therapy, intravenous injections, tube feeding, or bowel/bladder training; limited nursing care includes sterile dressings, irrigation, or hypodermic injections; routine nursing care includes enemas, blood pressures, and temperature, pulse, or respiration checks; and personal nursing care includes a rub or massage, a special diet, medication or other treatment, or assistance in personal hygiene or eating. A resident receiving multiple types of services, was classified at the higher level of nursing care.

Source: Health: United States, 1975, Public Health Service, U.S. Department of Health, Education, and Welfare.

The survey demonstrated that there was a significant gap between the percentage of the SNF population needing specialized rehabilitative services and the percentage actually receiving them. An estimated 47 percent of the patients needed physical therapy services, 35 percent needed occupational therapy, and 13 percent needed speech therapy. However, of the numbers requiring care, only 30.7 percent actually received physical therapy, 10.9 percent received occupational therapy, and 10.8 percent received speech therapy.

# PART III

# Health Financing and Delivery Systems of Selected Foreign Nations

In nearly every major industrialized country throughout the world, National Governments have assumed increasing responsibility for the provision and financing of health care to their citizenry. Many authorities in the health field have suggested that the experiences of these nations in the operation of their health care programs may reveal valuable insights for the United States. In the course of recent deliberations over national health insurance legislation, Members of Congress and the American public have expressed a growing interest in foreign health care systems and their possible relevance to this country.

Because the characteristics of each foreign system are largely a response to that country's unique social and political setting, no one system as a whole can be readily transferrable to another nation. Differences in social, economic, and governmental institutions, political philosophies, national priorities, modes of living, geographic and environmental conditions, inevitably limit to some extent the relevance and validity of any broad-scale international comparisons. In addition to these factors, there is a significant lack of sufficient comparable data on costs, utilization, conditions of practice, and public acceptability under the various systems.

Therefore, this report on the health care systems of selected foreign countries is intended only as a factual description of the main elements of each country's program—the people covered, the scope of benefits, the methods of financing and administration, and the mechanisms used to reimburse providers of health services. No attempt has been made to evaluate the relative success, effectiveness, or merits of the various programs, or to isolate aspects of each country's program which might be relevant to the United States. That process is up to the reader.

Seven countries have been selected for description in this report—Canada, France, United Kingdom, Japan, Sweden, the Union of Soviet Socialist Republics, and West Germany. These countries have been selected as representative examples of widely divergent approaches to health care financing and delivery. Not all of these countries can even be said to have national health insurance programs. For example, in the case of Great Britain and the U.S.S.R., health care is provided and financed through a nationalized health service in which the government owns and operates the facilities and employs the health personnel.

In Japan and West Germany independent health insurance societies or funds play a significant role in the administration of what can truly be termed a health insurance program; in these countries, the various insurance funds may offer differing levels of benefits and charge different contribution rates, depending on the needs, wishes, and resources of the fund members. The programs in France and Sweden are characterized by decentralized administration through semipublic sickness insurance funds operating at the local level. In Canada, each of the 10 Provinces administers a separate program, under general guidelines from the Federal Government, and may provide for the use of insurance carriers as nonprofit fiscal intermediaries.

The historical development of national health care programs abroad considerably predates interest in such a program in this country. Germany led the way with a compulsory health insurance program for a large part of the German labor force, instituted as early as 1883. Japan became the first Asian country to introduce a social insurance law with the 1922 passage of an act dealing with workers' health insurance.

Virtually 100 percent of the resident population is covered for comprehensive health services in Great Britain, Japan, Sweden, and the U.S.S.R. In the remaining countries, approximately the following percentages of the population are covered: France—98.5 percent; Canada—99.2 percent; and West Germany—90 percent.

# Chapter 1. Canada

## INTRODUCTION

Canada's national health insurance program consists of two distinct parts—a hospital and outpatient diagnostic services plan and a medical care plan covering primarily physicians' services. The two parts of the program were developed and enacted separately almost 10 years apart. Separate and different arrangements between the Federal Government in Ottawa and the various Provinces govern the operation of each plan.

Prior to development of its hospital and medical insurance plans, Canada had embarked on several programs which were to prove to be precursors of a nationwide system of health insurance. In 1948, the Federal Government had introduced a program of National Health Grants, offering support for a wide range of Provincial health services, including health planning, public health measures, hospital construction, and professional medical training. The activities supported by these grants-in-aid to the Provinces were regarded as fundamental prerequisites to a national health insurance program.

At about the same time, several Provinces began to establish government sponsored hospital and medical insurance plans. By the time the Federal hospital insurance program was enacted in 1957, four Provinces had instituted Provincial hospital programs, a factor which "undoubtedly . . . helped to pave the way for development of a national health insurance program and (contributed to) its being placed on a Federal-Provincial basis." [1]

During the post-World War II period, Canada had also experienced a rapid growth of voluntary health insurance plans, a development which may have temporarily decreased interest in a government-sponsored national health insurance program. By the end of 1954, an estimated 3.6 million Canadians were covered for hospital insurance under various nonprofit plans and 3.2 million under insurance company plans. An additional 2.7 million people were covered by nonprofit medical care plans (typically "physician-sponsored" plans somewhat similar to Blue Shield plans in the United States), with about 1.3 million of those insured having comprehensive coverage. Another 2.9 million were covered by insurance companies for surgical benefits and 1.5 million for medical (nonsurgical) benefits. All in all, about 9 million people, or somewhat over half of the total population, had some form of private health insurance coverage.

In the years preceding passage of the Federal Medical Care Act in 1966, a number of Provinces introduced government-sponsored medical care insurance plans. In 1962, Saskatchewan established a universal, compulsory, publicly operated medical insurance plan. Over the next four years, three other Provinces (Alberta, British Columbia, and Ontario) began operating voluntary subsidized medical insurance schemes.[2] By the end of 1966, an estimated 80.1 percent (16.2 million) of the Canadian population was covered for medical expenses under a combination of voluntary health insurance plans (insurance company plans, physician-sponsored plans, employer or union-sponsored plans, cooperative plans, and plans offered through government agencies) and miscellaneous plans (including the compulsory Saskatchewan medical care plan, social assistance plans, and plans for the Armed Forces, Indians, and Eskimos).[3]

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[1] Louis Reed, "The Canadian Hospital Insurance Program." Public Health Reports, Feb. 1962: 93.

## Hospital Insurance Program [4]

In 1957, the Canadian Government enacted the Hospital Insurance and Diagnostic Services Act, under which the Federal Government agreed to bear approximately half the cost of Provincial programs for the provision of general hospital care to their populations. The act came into effect on July 1, 1958, with five Provinces having signed participating agreements. By January 1, 1961, the last of the Provinces had programs underway. Under the terms of the Federal legislation, each participating Province is required to make insured services available to all its residents on uniform terms and conditions, without exclusion on grounds of age, income, or preexisting conditions. Residents of the Province are defined as those persons legally entitled to remain in Canada who make their homes and are ordinarily present in the Province.

### COVERAGE

By the end of 1974, all or virtually all of the net population of each Canadian Province was entitled to receive insured hospital services. The "net population" of Canada reached almost 22 million in 1974; this figure excludes members of the Armed Forces, the Royal Canadian Mounted Police, and inmates of penitentiaries, who are not entitled to receive insured services, their medical care being otherwise provided for.

Coverage is automatic or compulsory in most Provinces. In the case of Ontario, coverage is mandatory for employee groups of 15 or more, and it remains voluntary for the rest of the population. Persons living in Alberta may "opt-out" on a yearly basis, but such choice affects coverage under both the hospital and medical insurance plans.

Provisions governing the coverage of immigrants vary from Province to Province. Some provide coverage from the day of arrival, while others may require a 3-month waiting period. Canadian residents who move to another Province are covered for at least 2 months (subsequently the individual qualifies for benefits in the new Province).

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[2] For an overview of the development of these Provincial medical insurance plans, see "Medical Services Insurance: The Next Phase in Canada's National Health Program," by Frederick D. Mott, M.D., Medical Care Review, July and August, 1967.

[3] C. Howard Shillington, "The Road to Medicare in Canada." Del Graphics Publishing Dept., Toronto, 1972: 200.

[4] Due to the fact that the hospital and medical care insurance programs were enacted almost 10 years apart, and that, at the present time, the two programs are still administered and financed through separate and different arrangements, this report is subdivided into two main sections—the first section dealing with the hospital program, the second with the Federal-Provincial medical care plans.

## BENEFITS

Federal law requires that certain specified benefits be covered under any Provincial plan participating in the hospital insurance program. All 10 Provinces and the Northwest and Yukon Territories provide the following as insured patient benefits:

(1) Accommodation and meals at the standard ward level.
(2) Necessary nursing service.
(3) Laboratory and diagnostic services.
(4) Drugs and biologicals.
(5) Use of operating and case room and anesthetic facilities.
(6) Routine surgical supplies.
(7) Use of radiotherapy and physiotherapy facilities where available.

Excluded from coverage are services provided in tuberculosis and mental hospitals and custodial institutions. Most Provinces cover directly, or under their hospital insurance programs at their own expense, benefits for tuberculosis and mental hospital care, and home care; such services are not presently eligible for cost-sharing with the Federal Government. Nursing home care is also not ordinarily a benefit. Ontario is an exception in this regard, since it does extend such benefits when medically necessary, subject to a daily copayment levied on the patient. Alberta covers services provided in "auxiliary hospitals" where the patient's stay exceeds 120 days, subject to a $3 a day copayment after the 120th day; such extended care is presumably closer to that provided in skilled nursing homes than in active treatment hospitals.

To the required benefits may be added, by separate agreements between the Federal and Provincial Governments, specified outpatient and emergency services. Provinces are free to choose which, if any, outpatient services they will provide as insured services. All Provinces include emergency services and outpatient followup and a varying list of other outpatient benefits. For a detailed comparison of optional benefits under each Province's hospital insurance plan, see Appendix I to this section.

Federal law does not prohibit Provinces from imposing authorized charges on patients for insured services, so long as such cost-sharing does not deter patients, particularly low-income persons, from obtaining needed care. As of 1974, however, only three plans (those operating in British Columbia, Alberta, and the Northwest Territories) utilized patient cost-sharing—in these cases, in the form of nominal daily copayments for inpatient hospital care.

Although participation has been extremely reduced as a result of the government health insurance plans, private health insurance organizations continue to offer coverage for a variety of services supplemental to, or not insured under, the government plans. The extent of participation and the nature of the benefits provided under these private plans is described in the section of this report dealing with benefits under the Federal-Provincial Medical Care Plans.

## ADMINISTRATION

The Federal law allowed the Provinces to make their own determinations with regard to the method to be used for administration of the hospital plan. Each Province was required, however, to designate a Provincial authority charged with direct administrative responsibility for the plan. In no case did a Province utilize private health insurance carriers for any type of intermediary administrative function (in contrast, several Provinces were later to make use, at least on a temporary basis, of private carriers for various functions under the medical insurance plans). By the end of fiscal year 1974, six Provinces and two Territories were using departmental administration (either directly through the Provincial ministry of health or through a divison of the Provincial department of health) and four (Alberta, Manitoba, Nova Scotia, and Prince Edward Island) were administering the plan through separate public commissions.

The Federal Government does not share with the Provinces any administrative costs incurred under the Provincial plans. In 1966, the administrative expenses of the 10 Provinces totaled $12,200,000, equal to 1.1 percent of the total expenditures for hospital care under their programs. Administrative expenses as a percentage of benefit expense ranged from 0.37 percent in Alberta to 3.49 percent in Manitoba. In general, the administrative expense ratios were higher in those Provinces that raised some of the funds for their programs through premiums. In these Provinces, administrative expenses include the cost of collecting premiums. The following table for fiscal 1966 shows for each Province the total expenditures for hospital care, the administrative expense, the ratio of administrative to hospitalization expense, and administrative expense per capita of the Provincial population.

*Canada: Administrative expense of hospital insurance, 1966* [1]

| Fiscal year ending— | Province | Total hospitalization expense | Administrative expense | Ratio administrative to hospital expense (percent) | Net population 1966 | Per capita administrative expense |
|---|---|---|---|---|---|---|
| Mar. 31 | British Columbia | $76, 207, 739 | $635, 608 | 0. 83 | 1, 862, 000 | $0. 34 |
| Do | Alberta | 77, 503, 057 | 286, 826 | . 37 | 1, 447, 000 | . 20 |
| Dec. 31 | Saskatchewan | 57, 405, 592 | 1, 045, 369 | 1. 82 | 950, 000 | 1. 10 |
| Do | Manitoba | 53, 352, 178 | 1, 859, 764 | 3. 49 | 952, 000 | 1. 95 |
| Do | Ontario | 392, 592, 994 | 6, 015, 426 | 1. 53 | 6, 783, 000 | . 88 |
| Mar. 31 | Quebec | 351, 209, 381 | 1, 576, 200 | . 45 | 5, 744, 000 | . 27 |
| Do | New Brunswick | 28, 996, 680 | 270, 724 | . 93 | 620, 000 | . 44 |
| Do | Nova Scotia | 33, 720, 157 | 239, 497 | . 71 | 742, 000 | . 32 |
| Dec. 31 | Prince Edward Island | 4, 251, 047 | 131, 707 | 3. 10 | 107, 000 | 1. 23 |
| Mar. 31 | Newfoundland | 23, 562, 380 | 160, 000 | . 68 | 504, 000 | . 32 |
| Total, all Provinces | | 1, 098, 801, 205 | 12, 221, 121 | 1. 11 | 19, 801, 000 | . 62 |
| Federal Government | | | 470, 000 | | | |
| Total Federal Provincial Programs | | 1, 098, 801, 205 | 12, 691, 121 | 1. 15 | 19, 801, 600 | . 64 |

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[1] Annual Report 1973–74, Hospital Insurance and Diagnostic Services, for fiscal year ended Mar. 31, 1974. Department of National Health and Welfare, Ottawa, Canada, 1974: 41.

Source: Prepared by Office of Research and Statistics, Social Security Administration, U.S. Department of Health, Education, and Welfare, Nov. 7, 1968, Research and Statistics note No. 21–1968.

## FINANCING

The Government of Canada contributes out of consolidated revenues approximately 50 percent of the net operating costs of each Provincial hospital insurance plan, based on a formula which gives special help to the poorer Provinces. Federal contributions are calculated on the basis of the following formula: the sum of 25 percent of the per capita cost of inpatient services in Canada as a whole, and 25 percent of the per capita cost of inpatient services in the Province, multiplied by the average number of insured persons in that Province. In addition, the Federal Government contributes with respect to outpatient services an amount that is in the same proportion to the cost of these services (less any authorized charges) as the amount contributed for inpatient services is to the cost of inpatient services. As one authority has noted:

> The effect of the formula is that high-cost Provinces receive a lower percentage of their costs from the Federal Government than do the low-cost Provinces. The inclusion in the formula of the national per capita cost acts as a deterrent to the high-cost Provinces, since the more that Provincial costs exceed the national costs, the lower will be the percentage of the Federal contributions.[5]

The following tables indicate the cost of inpatient services for 1971, for Canada as a whole and by individual Province, and the contributions by the Federal Government for insured inpatient services based on the formula explained above.

*Cost of inpatient services, 1971, net population, June 1, 1971; total and 25 percent per capita cost, 1971, by Province* [1]

| Province | Cost of inpatient services, 1971 | Net population June 1, 1971 | Per capita cost, 1971 | |
|---|---|---|---|---|
| | | | Total | 25 percent |
| Newfoundland | $37, 921, 239 | 521, 040 | $72. 7799 | $18. 1950 |
| Prince Edward Island | 7, 909, 800 | 110, 357 | 71. 6747 | 17. 9187 |
| Nova Scotia | 66, 674, 542 | 774, 018 | 86. 1408 | 21. 5352 |
| New Brunswick | 56, 889, 281 | 628, 334 | 90. 5399 | 22. 6350 |
| Quebec | 671, 829, 017 | 6, 012, 446 | 111. 7397 | 27. 9349 |
| Ontario | 804, 768, 804 | 7, 670, 746 | 104. 9140 | 26. 2285 |
| Manitoba | 90, 529, 069 | 981, 365 | 92. 2481 | 23. 0620 |
| Saskatchewan | 84, 736, 939 | 922, 322 | 91. 8735 | 22. 9684 |
| Alberta | 163, 067, 437 | 1, 617, 198 | 100. 8333 | 25. 2083 |
| British Columbia | 188, 086, 958 | 2, 171, 668 | 86. 6094 | 21. 6524 |
| Yukon | 1, 093, 742 | 18, 333 | 59. 6597 | 14. 9149 |
| Northwest Territories | 3, 201, 911 | 34, 464 | 92. 9060 | 23. 2265 |
| Canada | 2, 176, 708, 739 | 21, 462, 291 | 101. 4201 | 25. 3550 |

[1] Annual Report 1973–74, Hospital Insurance and Diagnostic Services, for fiscal year ended Mar. 31, 1974. Department of National Health and Welfare, Ottawa, Canada, 1974: 41.

Source: Prepared by Office of Research and Statistics, Social Security Administrations U.S. Department of Health, Education, and Welfare, Nov. 7, 1968. Research and Statistic, note No. 21–1968.

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[5] Lloyd Detwiller, "The History and Philosophy of Health Care in Canada and British Columbia," in National Health Care: the British Experience, Office of Comprehensive Health Planning, Olympia, Wash., 1971: 16.

*Contribution by Canada with respect to inpatient services, 1971*[1]

| Province | 25 percent of national per capita | 25 percent of provincial per capita | Less 25 percent per capita authorized charges | Aggregate per capita cost | Average number of insured persons | Inpatient contribution by Canada |
|---|---|---|---|---|---|---|
| Newfoundland | $25. 3550 | $18. 1950 | ------------ | $43. 5500 | 521, 040 | $22, 691, 292 |
| Prince Edward Island | 25. 3550 | 17, 9187 | ------------ | 43. 2737 | 110, 357 | 4, 775, 556 |
| Nova Scotia | 25. 3550 | 21. 5352 | ------------ | 46. 8902 | 774, 018 | 36, 293, 859 |
| New Brunswick | 25. 3550 | 22. 6350 | ------------ | 47. 9900 | 628, 334 | 30, 153, 749 |
| Quebec | 25. 3550 | 27. 9349 | ------------ | 53. 2899 | 6, 012, 446 | ------------ |
| Ontario | 25. 3550 | 26. 2285 | ------------ | 51. 5835 | 7, 661, 888 | 395, 227, 000 |
| Manitoba | 25. 3550 | 23. 0620 | ------------ | 48. 4170 | 1, 009, 578 | 48, 880, 738 |
| Saskatchewan | 25. 3550 | 22. 9684 | $0. 7133 | 47. 6101 | 929, 367 | 44, 247, 256 |
| Alberta | 25. 3550 | 25. 2083 | . 5771 | 49. 9862 | 1, 617, 198 | 80, 837, 583 |
| British Columbia | 25. 3550 | 21. 6524 | . 4658 | 46. 5416 | 2, 171, 668 | 101, 072, 903 |
| Yukon | 25. 3550 | 14. 9149 | ------------ | 40. 2699 | 18, 333 | 738, 268 |
| Northwest Territories | 25. 3550 | 23. 2265 | . 5310 | 48. 0505 | 34, 464 | 1, 656, 012 |
| Total contributions by Canada for inpatient services, 1971 | | | | | | 766, 574, 216 |

[1] Annual Report 1973–74, Hospital Insurance and Diagnostic Services, for fiscal year ended Mar. 31, 1974. Department of National Health and Welfare, Ottawa, Canada, 1974: 41.

Source: Prepared by Office of Research and Statistics, Social Security Administration, U.S. Department of Health, Education, and Welfare, Nov. 7, 1968. Research and Statistics note No. 21–1968.

*Provincial costs versus Federal contributions under the hospital insurance and medical care programs 1973–74*[1]

| Province | Hospital insurance program | | | | Medical care program | | | |
|---|---|---|---|---|---|---|---|---|
| | Estimated Provincial costs (thousands) | Estimated Federal contributions (thousands) | Contributions of Provincial costs (thousands) | Balance of Provincial costs (percent) | Estimated Provincial costs (thousands) | Estimated Federal contributions (thousands) | Contributions of Provincial costs (percent) | Balance of provincial costs (percent) |
| Newfoundland | $58, 824 | $33, 866 | $57. 6 | 42. 4 | $20, 434 | $16, 657 | 81. 5 | 18. 5 |
| Prince Edward Island | 11, 388 | 6, 807 | 59. 8 | 40. 2 | 4, 752 | 3, 529 | 74. 3 | 25. 7 |
| Nova Scotia | 97, 085 | 53, 049 | 54. 6 | 45. 4 | 38, 948 | 24, 552 | 63. 0 | 37. 0 |
| New Brunswick | 85, 108 | 43, 631 | 51. 3 | 48. 7 | 26, 539 | 20, 093 | 75. 7 | 24. 3 |
| Quebec | 912, 822 | 438, 750 | 48. 1 | 51. 9 | 370, 835 | 188, 332 | 50. 8 | 49. 2 |
| Ontario | 1, 072, 851 | 530, 230 | 49. 4 | 50. 6 | 550, 442 | 246, 351 | 44. 8 | 55. 2 |
| Manitoba | 133, 608 | 70, 944 | 53. 1 | 46. 9 | 54, 030 | 31, 703 | 58. 7 | 41. 3 |
| Saskatchewan | 115, 481 | 61, 280 | 53. 1 | 46. 9 | 46, 997 | 28, 189 | 60. 0 | 40. 0 |
| Alberta | 241, 858 | 121, 106 | 50. 1 | 49. 9 | 94, 389 | 53, 159 | 56. 3 | 43. 7 |
| British Columbia | 268, 734 | 142, 225 | 52. 9 | 47. 1 | 162, 758 | 72, 137 | 44. 3 | 55. 7 |
| Yukon Territory | 1, 878 | 1, 142 | 60. 8 | 39. 2 | 1, 144 | 619 | 54. 1 | 45. 9 |
| Northwest Territories | 5, 099 | 2, 476 | 48. 6 | 51. 4 | 1, 667 | 1, 146 | 68. 7 | 31. 3 |
| Canada | 3, 004, 736 | 1, 505, 506 | 50. 1 | 49. 9 | 1, 372, 935 | 686, 467 | 50. 0 | 50. 0 |

[1] Maurice LeClair, "The Canadian Health Care System," in "National Health Insurance: Can We Learn from Canada?" ed. by Spyros Andreopoulos. John Wiley & Sons, New York, 1975: 39.

Notes: The Federal contribution for the Province of Quebec, under the hospital insurance program is paid through tax rebate under the established programs (interim arrangement) acts, effective 1965–66.

The Provincial costs under the hospital insurance program are calculated on a "calendar year" basis, but have been "fiscalized" for comparison purpose with the medical care program. The last years for which actual audited costs are available is calendar year 1971 for hospital insurance and fiscal year 1972–73 for medical care.

The data in two preceding tables indicate that the Federal contribution for inpatient hospital services in 1971 ranged from 60 percent of Provincial costs for Newfoundland and Prince Edward Island to 49 percent of Ontario's costs. The table below shows Provincial costs versus Federal contributions under both the hospital and medical insurance programs for 1973–74. Note that these data, more recent than that used in the preceding tables, include cost-sharing expenditures under the hospital program for both inpatient care and the outpatient diagnostic services also insured under the program.

The actual costs of Provincial hospital plans which are shared by the Federal Government are, in general, the operating costs of hospitals determined in accordance with recognized and generally accepted accounting principles and procedures, and approved by the Provincial authority administering the plan. The Federal law specifically excluded from shared costs any amounts spent on the capital cost of land, buildings, or physical plant; payment of any capital debt or interest on debt incurred before effective date of the agreement; or any provision for depreciation on land value, buildings, or physical plant. However, cost or depreciation of items of furniture and equipment is shared.

In addition to financial aid, the Federal Government provides technical assistance to the Provinces, endeavors to assure coordination among the Provincial programs, and holds Federal-Provincial conferences for discussion of problems relating to the program.

The Provinces finance their share of program costs from a variety of sources—general revenues, premiums, and special taxes. Additionally, British Columbia, Alberta, and the Northwest Territories use copayment amounts, although these amounts are deducted from overall program costs before the Federal share is computed. In Ontario and Alberta, a joint monthly premium is charged for both the hospital and medical insurance programs (in Ontario, $11 for single persons, $22 for families; in Alberta, $5.75 for single subscribers, $11.50 for family coverage). Premium assistance is available both in Ontario and Alberta for certain categories of residents with limited incomes, and premium exemption is provided for residents over age 65. Nova Scotia relies on a provincial health services tax. British Columbia and the remaining Provinces finance the Provincial share of costs out of general Provincial revenue. Prior to 1974, Manitoba and Saskatchewan had utilized premiums for partial financing of the Provincial costs, but both Provinces have since abandoned this method. (In the case of Saskatchewan, fines could previously be incurred for nonpayment of the compulsory premium.)

Over the past few years, the Government of Canada has been actively recommending to the Provinces that measures be taken to control the rate of cost increase under both the hospital and medical programs. Ottawa has given the required 5-years notice of its intention to renegotiate with the Provinces the basis of Federal participation in the Hospital Insurance and Diagnostic Services Act. The proposed formula for future Federal contributions and other issues surrounding the problems of rising health costs in Canada are discussed at the end of the section of this report dealing with the medical insurance program.

### REIMBURSEMENT METHODS

All Provinces have instituted a system of annual prior budget review of hospital expenses insured under Provincial hospital plans. Each hospital is required to submit a detailed budget before the beginning of the year, giving data on volume of services provided in the last complete year, an estimate of volume of services to be provided in the current year, and an estimate of services in the year being budgeted for. These budgets are reviewed by a rate board consisting of senior members of the staff of the Provincial agency, as well as by persons familiar with the operation of that hospital and other hospitals. From the hospitals' total expenses are deducted, in accordance with the Federal definition of shareable hospital costs, generally: (1) At least 50 percent (some Provinces require deduction of 60 or 100 percent) of estimated income from charges for semiprivate and private accommodations, and (2) income from other sources, such as patient income from workmen's compensation cases, and noncovered persons, outpatient services if not covered by the hospital insurance program, cafeteria services, and so forth. The hospital receives its approved costs for the year, with slight increments or decrements for days of service in excess of or below the original estimates.

The Provincial authority sets all per diem hospital rates—for ward, semiprivate, and private accommodations. Provinces have adopted different policies with regard to what percentage of the differential between ward and semiprivate or private accommodation may be retained by the hospital and what percentage must be returned to the government. In Newfoundland, Nova Scotia, and Saskatchewan, for example, hospitals may retain 50 percent of the room differential. In Prince Edward Island, on the other hand, the hospital is not permitted to retain any portion of the differential.

Initial implementation of prospective budgeting for hospitals apparently did not produce any significant strain. According to government sources in Ontario, for example, hospitals operated under prospective budgeting for 1-year's time as a "dry run" and in the following year implemented the procedure on a regular basis without noticeable difficulties. The following remarks by Donald M. Cox, former Deputy Minister of Hospital Insurance, Victoria, British Columbia, illustrate how the prospective budgeting process operates in one Province:

> Hospitals are expected to present to our service before the end of each calendar year detailed estimates of their operating costs and occupancy for the coming year. In practice it has been impossible in most years for hospitals to send in estimates that soon because their staffs are almost all unionized, and bargaining often extends well into the new year. Estimates are of little value if salary costs are not known.
>
> Upon receipt of estimates by our service, they are tabulated and are then reviewed in detail by the consultants who pay particular attention to staffing patterns, staffing requirements, service developments, diagnostic and treatment programs, and by the accountants who are responsible for development of cost comparisons and particular examination of supply and other nonsalary costs. The recommendations of the reviewing staffs are considered by the rate board of our service, composed of four senior personnel under the chairmanship of the Assistant Deputy Minister. The board must, of course, reconcile recommendations with the overall money voted by the legislature for the operation of the service.

> Firm budgets are then established and all-inclusive per diem rates set.
>
> As a simplified example, a hospital may have an acceptable estimate of 100,000 adult and child inpatient days of care with an approved budget setting a gross expenditure of $5,600,000 and estimated sundry revenue of $600,000 from outpatient charges, newborn days at a fixed rate, semiprivate and private room charges, and so forth. After deducting the sundry revenue, there remains $5 million to be recovered from inpatient charges. On a basis of 100,000 days' care, this works out to an inclusive rate of $50 per day.
>
> This rate is used for billing purposes, but it is recognized that no hospital will achieve its exact estimate of days of care, and this is why we use the term "firm" rather than "fixed" budget. If the hospital in question during the year is 500 days short of its estimate, the only saving is in supplies calculated at $4 per day. That hospital would be paid $500 less $4 or $46 per day for its readiness to serve, or overhead, cost for the 500 days short of the approved estimate. If the hospital had 500 days over estimates, it would be paid only the $4 supply cost for the extra 500 days.
>
> Our principal medical teaching hospital has an inclusive standard ward per diem rate of $58.90 a day; the next hospital in size, $56.40 a day; and a typical community hospital of 125 beds, a rate of $43 a day.
>
> The cost of inpatient hospital care for this year will average approximately $81.60 per person resident in the Province.
>
> In notifying hospitals of approved budgets, we outline the broad areas of reductions and, in some cases, increases recommended by our rate board. However, once a budget has been set, a hospital is free to spend its income as it sees fit. It can spend more on salaries and less on other costs or make any other variations that it wishes.
>
> Finally, after such year-end adjustments are approved, if a hospital has sustained a deficit it must find funds to meet the deficit and if it has a surplus it retains the surplus to use as it sees fit, and hospitals have assurance that they are not going to be penalized by having accumulated a surplus. We don't take the money away from them the next year and cut them down.
>
> Over the years, a good many of the hospitals have had surpluses and a good many others have had deficits. I recently met with the board and the administration of a 500-bed hospital at their request. They were concerned about a projected deficit for this year. Over the past 10 years that hospital had surpluses totaling $188,000 and deficits totaling $111,000.[6]

As noted earlier, the Federal Government does not contribute to capital costs under the Provincial hospital insurance plans. Between 1948 and 1970, a separate national grants program was in operation at the Federal level to assist Provinces in financing hospital construction. Since 1970, however, allocation of Federal health resources funds has been limited to teaching hospitals. The Federal Government no longer shares with the Provinces costs of capital construction or modernization of nonteaching facilities. At the Provincial level, there is considerable variation with regard to capital financing of hospitals:

> One Province pays charges for depreciation (but requires that it be funded), notwithstanding the lack of Federal reimbursement. Several have set up special capital cost funds from which payments are made to hospitals which they may use for new construction or for

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[6] Donald Cox, "Development of the British Columbia Hospital Insurance Service," in National Health Care: The British Columbia Experience, Office of Comprehensive Health Planning, Olympia, Wash., 1971: 34–37.

> interest on or repayment of debt. Alberta took over the existing debts of all hospitals when it instituted its program and provides 100 percent of the cost of all new approved construction.[7]

In Ontario, the Provincial government provides two-thirds of the cost of basic construction of community hospitals and guarantees 100 percent of the cost of constructing teaching hospitals (the Federal Government shares in the cost of the latter facilities). In all Provinces, there can be no hospital construction without approval of the Provincial agency. "The reason for this is obvious. Under the programs, the Provinical government is meeting 100 percent of the cost of operation of all hospitals in the Province; it must, therefore, be able to approve of any new plant." [8]

For example, in Ontario, the government recently declared a moratorium on all community hospital construction and even took steps to reduce what was considered an unnecessarily high bed/population ratio (approximately 5/1,000 in 1971). For fiscal year 1973, hospital budgets were to be based on a 4.5 ratio of beds per 1,000 population. If a hospital exceeded the 4.5 ratio, the Province was not to provide financing for operating costs of additional beds.

For additional information on various aspects of the Provincial hospital plans, their financing, and reimbursement procedures, see Appendix I to this section.

### MEDICAL CARE INSURANCE PROGRAM

In December 1966, Canada entered the second phase of its national health insurance program with passage of the Medical Care Act, which became effective July 1, 1968, and committed the Federal Government to contributing to participating Provinces approximately half the costs of insured services under Provincial medical care plans that satisfied the following criteria:

(1) Comprehensive coverage for all medically required services rendered by a physician or surgeon. There can be no dollar limit or exclusions except on the grounds that the services were not medically required. The benefit coverage must be administered in such a way that there will be no financial impediment or preclusion to an insured person receiving necessary medical care. Certain surgical-dental services rendered by dental surgeons in hospitals have been included as benefits from July 1, 1968.

(2) Universal availability to all eligible residents of a participating Province on equal terms and conditions and covering, in addition, at least 90 percent of the total eligible population (and 95 percent during the year commencing April 1, 1971). This insures access to coverage by all residents and prevents premium discrimination on account of previous health, age, nonmembership in a group or other consideration. At the same time, subsidization in whole or in part for low-income groups is permitted if a plan is financed by means of a premium system.

(3) Portability of benefits when the beneficiary is temporarily absent from his own Province and when he is moving from one participating Province to another. It is not related to employment insurance groups and, consequently, coverage is not lost when an individual changes job or residence.

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[7] Louis S. Reed, "The Canadian Hospital Insurance Program." Public Health Reports Feburary 1962: 100.

[8] Ibid., p. 101.

(4) Administration on a nonprofit basis by a public authority which is accountable to the Provincial government for its financial transactions.[9]

Two Provinces, British Columbia and Saskatchewan, entered the Federal program on the effective date. By January 1, 1971, all 10 Provinces had signed participating agreements with the Yukon and Northwest Territories entering the program by April of 1972.

The act also allows Provincial authorities to designate nongovernmental organizations as agencies permitted to undertake restricted functions in connection with premium-collection or claims-payment administration of the Provincial plan. Such agencies must be nonprofit and the payment of claims must be subject to assessment and approval by the Provincial authority.

Some of the main differences between the hospital insurance and medical care insurance programs were summarized by one author as follows:

> 1. The chief objections of Provincial governments to hospital insurance were both the concept of the Province having to sign an "agreement," with the Federal intervention that the the agreement entailed, and the requirement of a Federal audit. These requirements were eliminated in the medical care program.
> 2. The implicit assumption in 1956 that Provincial hospital plans would be administered by a public agency was made explicit in the medical plan. This led to the withdrawal of commercial insurance coverage for these benefits in all Provinces, the use of voluntary plans as "agents" of the government in some Provinces, and the winding up of the voluntary plans in other Provinces.
> 3. The financial formula ignores Provincial variations in per capita costs and pays to each Province one-half of the national per capita cost in respect of each member of its insured population. Thus the equalization factor is greater than in the hospital financing formula (80 percent of the cost in Newfoundland, but only 45 percent in Ontario).[10]

### COVERAGE

Of an estimated 22.2 million Canadian residents eligible for coverage under Provinical medical care plans in fiscal year 1973–74, very few currently remain uninsured. One hundred percent of the eligible population are now insured in Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Manitoba, Saskatchewan, the Northwest Territories, and the Yukon Territory. Virtually 100 percent of the eligible population in Alberta, British Columbia, and Ontario are covered.

The methods for determining the number of insured persons in a Province differ, since the method used by a Province to finance the Provincial share of costs has a direct bearing on the availability of an actual count of insured persons. Thus, in some Provinces the number of insured persons is estimated from the Provincial population as defined in the Medical Care Act and in other cases the number of insured persons is based on a more precise determination.

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[9] Taken from the Annual Report of the Minister of National Health and Welfare, respecting operations of the Medical Care Act for the fiscal year ending March 31, 1974. Ottawa: Information Canada, 1974: 2.

[10] Malcolm Taylor, "The Canadian Health Insurance Program." Public Administration Review, Jan.–Feb. 1973: 36.

The Medical Care Act defines "population" to mean the population of the Province on the first day of October in that fiscal year as certified by the Chief Statistician of Canada, after excluding members of the Canadian Armed Forces, Royal Canadian Mounted Police, and persons serving a term of imprisonment in a penitentiary as defined in the Penitentiary Act. The exclusions amount to some 0.5 percent of the total population.

Insurable residents of a participating Province who are eligible and entitled to receive insured services under any other act of the Parliament of Canada or under any law of a Province relating to workmen's compensation are not entitled to benefits under the Medical Care Act. For example, war veterans entitled to medical care under other Federal legislation are excluded from the benefit coverage of the Medical Care Act insofar as their compensable disability is concerned.[11]

### BENEFITS

For a participating Province to benefit from the Federal program, its own plan must provide for the financing of comprehensive physicians' services for all insurable residents without regard to their age, ability to pay, or other circumstances. In addition, the Medical Care Act empowers the Federal Government to include additional health care services provided by nonphysician professional personnel, under terms and conditions specified by the Governor-in-Council. Six Provinces presently cover the services of optometrists. Ontario, Alberta, and British Columbia also cover services performed by osteopaths, chiropractors, podiatrists, and certain other health personnel. Routine dental care is generally not a covered service, although there are exceptions—(1) in September 1974, Saskatchewan began phasing in an insured dental service plan for children up to 12 years of age, (2) Quebec has passed legislation for dental services, but the program has not yet been implemented, and (3) since January 1974, Alberta has extended routine dental care and optical care to residents over age 65 and their dependents. For a complete description of the differences among the various Provincial plans, see Appendix II.[12]

All Provinces now prohibit the sale of any private insurance duplicating in any way the benefits covered under the Federal-Provincial plans. However, most Provinces do allow nonprofit organizations and commercial insurers to supplement the government coverage; that is, for such typically noncovered items or services as dental care, drugs, ambulance service, et cetera. In some cases the Provincial government authority itself markets a separate supplemental package or licenses (as in the case of British Columbia) its nonprofit carriers acting as administrative agents for the government plan to sell supplemental benefits.

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[11] Annual Report of the Minister of National Health and Welfare, respecting operations of the Medical Care Act for the fiscal year ending Mar. 31, 1974, Ottawa, Canada: 28.

[12] Joseph G. Simanis, "National Health Systems in Eight Countries." U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics. DHEW Publication No. (SSA) 75-11924, U.S. Govt. Print. Off., Wash., DC, January 1975: 28.

Precise figures are not available on the extent of supplemental health insurance coverage from all combined sources—government agencies, nonprofit organizations, and commercial insurers—throughout the Provinces. The table below presents data obtained from the Canadian Association of Accident and Sickness Insurers (formerly, the Canadian Health Insurance Association) from its 1971 survey of health insurance benefits in Canada. Data reported in this 1971 survey were submitted by a total of 44 member insurers of the CAASI. The figures do not, therefore, reflect the extent of coverage under Provincial government-sponsored supplemental plans or plans sold through nonprofit organizations. Judging from the data presented in this table, it would appear that disability income insurance has become an attractive area for private insurers.

*Group and individual coverage in force (as of Dec. 31, 1971), direct premiums written and direct claims paid during 1971*

| | Group | | | | | Individual | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Contracts in force | Persons covered | | Direct premiums written | Direct claims paid | Persons covered | | Direct premiums written | Direct claims paid |
| | | Employees | Dependents | | | Principals | Dependents | | |
| Accidental death and dismemberment | 16,750 | 1,757,007 | (1) | $14,695,761 | $8,008,669 | (1) | (1) | (1) | (1) |
| Loss of income: | | | | | | | | | |
| Short term | 21,034 | 1,760,999 | (1) | 125,702,795 | 111,562,049 | 60,654 | (1) | $4,567,156 | $2,632,395 |
| Long term | 5,684 | 1,023,107 | (1) | 48,059,173 | 18,716,806 | 287,207 | (1) | 34,965,423 | 18,501,626 |
| Creditors | 35 | 387,794 | (1) | 12,495,979 | 7,483,781 | (1) | (1) | (1) | (1) |
| Extended health care [2] | 16,131 | 1,995,840 | 3,929,146 | 62,300,057 | 43,563,839 | 23,021 | 47,110 | 2,436,298 | 1,273,631 |
| Drug expense [2] | 1,662 | 105,191 | 222,688 | 2,762,727 | 2,413,567 | 7 | 18 | 2,119 | 19 |
| Supplementary hospital [2] | 4,758 | 497,198 | 976,751 | 8,107,639 | 4,410,980 | 5,855 | 6,370 | 170,606 | 107,207 |
| Dental | 642 | 59,862 | 125,241 | 4,769,334 | 3,542,220 | (1) | (1) | (1) | (1) |
| Miscellaneous | 287 | (1) | (1) | 1,829,396 | 1,280,410 | (1) | (1) | 21,854,718 | 9,090,350 |
| Not allotted by type of coverage | (1) | (1) | (1) | 16,044,574 | 13,011,417 | (1) | (1) | 5,689,949 | 4,430,802 |
| Total | (1) | (1) | (1) | 296,767,435 | 213,993,738 | (1) | (1) | 69,686,269 | 36,036,030 |

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[1] The drug expense and supplementary hospital coverage reported was provided under contracts set up principally to provide those benefits only.

[2] Coverage providing payments to cover a wide range of health care expenses such as ambulance services; crutches, braces and other medical appliances; private-duty nursing; services of nonmedical practitioners and, in the majority of cases, prescribed drugs and hospital expenses. Coverage frequently extends to include most health care expenses not paid by Provincial government plans.

Source: Canadian Association of Accident and Sickness Insurers, Toronto, Canada, 1971.

It has been reported by other sources that more than six million Canadians are presently insured under a wide variety of private health insurance plans, mainly through group enrollment. Such plans reportedly utilize deductibles (generally $25 per person per year or $50 per family) or coinsurance limiting amount of claims paid to 80 percent of total cost. It is common for such plans to have a life-time maximum of $5,000 to $50,000. Coverage for the cost of prescription drugs is reported to be one of the most important elements of group health plans, with about 85 percent of all claims for drugs.[13]

### FINANCING

Provinces can finance services in any manner they wish, but the act contains a provision the intent of which is that no insured person shall be impeded or precluded from reasonable access to insured services as a consequence of direct charges associated with the services received. A Province may adopt any method it wishes for the reimbursement of providers of services, subject only to the proviso that the fee schedule for authorized payments is on a basis that assures reasonable compensation for the services rendered.

The formula for calculating Federal contributions to the cost of Provincial plans is such that Provinces with relatively low per capita costs would be assisted by something more than half their Provincial costs. In general terms, the Federal contribution to a participating Province is an amount equal to (a) 50 percent of the average per capita cost for the year of all insured services in all participating Provinces, and (b) multiplied by the number of insured persons in each Province respectively. As under the hospital program, the Federal Government makes no contribution to administrative costs incurred by the Province. A two-percent income surtax (maximum $100), referred to as the social development tax, is used by the Federal Government to finance its share of the medical insurance program.[14]

The Provinces finance their share in the medical program from a variety of sources—general revenues in four Provinces, premium payments in five Provinces, et cetera. In Quebec, the program is financed through a 0.8 percent payroll tax on employers and personal income tax of an equal amount (up to a maximum contribution of $125). In some Provinces which utilize premium financing, persons over 65 or persons receiving some form of social assistance income pay no premiums. The Federal Government assumes payment of any required premiums for low-income Indians and Eskimos.[15]

The Federal contribution is paid to Provinces on the basis of regular monthly advance payments in order to allow the Provinces to reimburse physicians and other providers on a continuing basis:

> In order to expedite the payment of advances and, at the same time, to forestall the likelihood of a major financial adjustment after the end of each fiscal year, the formula which is used for the calculation of the advance payments provides for a holdback of up to 10 percent of the amount due to the Province. The formula for the advance payments, therefore, differs from the formula for the annual contribution, in that 45 percent of estimated national per capita cost is paid to the Provinces as advances on account of contributions.

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[13] "Canada: Private Health Insurance," Medical Care Review, May 1974: 623.

[14] Taylor, p. 36.

[15] Ibid.

> The remaining 5 percent of the national per capita cost multiplied by the average number of insured persons in a Province, plus or minus adjustment to actual costs, is paid to Provinces following receipt of final cost reports from all participating Provinces * * *.[16]

In 1975, the Government of Canada announced its intention to establish a ceiling on the amount of annual increase in the contributions the Federal Government would make to the Provinces under the terms of the Medical Care Act. The ceiling was to be effective for 1976 and subsequent years with regard to the per capita growth rate in Federal contributions to the Provinces. For 1976–77, the ceiling was to be 13 percent over the amount of Federal contributions in the preceding year, 10.5 percent for 1977–78, and 8.5 percent for 1978–79 and subsequent years. The reasons for this action are more fully described in the section of this report dealing with rising health costs in Canada.

### ADMINISTRATION

The Federal Medical Care Act of 1966 specified that Provincial "medicare" [17] programs be operated on a "nonprofit basis by a public authority subject to Provincial audit." Beyond these broad guidelines, the Provincial governments were free to make their own determinations with regard to the administration of the program at the Provincial level. The Federal law contained a provision which allowed Provincial authorities to designate certain nongovernmental organizations as agencies permitted to undertake restricted functions in connection with the day-to-day premium collection and claims payment administration of the Provincial plan. Thus, existing voluntary insurance carriers who so wished might apply for an agency arrangement under the Provincial authority. However, it would be necessary to handle this agency aspect of their business on a nonprofit basis and the actual payment of claims would, in accordance with the Federal act, be subject to assessment and approval by the Provincial authority.

The Federal medicare plan was considerably more flexible with regard to a potential role for private insurance carriers than was its predecessor, the hospital insurance and diagnostic services plan. The act which established the hospital insurance program has stipulated that Provincial plans be operated directly by a "public agency," thus effectively eliminating any possible role for nongovernmental organizations.

In 1967 a Federal-Provincial conference of health ministers was held in Ottawa to explore the ability of the Provinces to meet the Federal conditions and to interpret and clarify provisions of the Medical Care Act (which was to become operative on July 1, 1968). One of the major issues discussed at this conference centered around interpretation of "administration on a nonprofit basis by a public authority responsible to the Province and subject to public audit." According to press accounts, Federal Health and Welfare Minister Allan MacEachen stated on several occasions that:

> A Province could integrate a doctor-sponsored plan into its program or even designate a private insurance company to be its agent, to collect premiums and make payments, but that the assessment of claims and the determinations of payments represent a

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[16] Annual Report of the Minister of National Health and Welfare, respecting operations of the Medical Care Act, for the fiscal year ending Mar. 31, 1974:5.

[17] The term "medicare" is used in this report to denote the Federal medical care program, enacted in 1966.

> crucial function that should be undertaken by a public authority; and that the claim of insurance people, that with respect to health insurance, they represent a nonprofit organization, is a matter that could be verified in a Province proposing to use a private carrier.

Costs incurred in the administration of the medicare plan at the Provincial level were not shareable with the Federal Government. Provincial governments were presented, therefore, with a strong incentive to develop the least expensive type of administrative mechanism, presumably a single public agency rather than a mixture of public authority and multiple private agencies.

Seven Provinces are presently using public commissions for administration of the Provincial plan. The remaining Provinces and Territories have vested administrative responsibility either directly in the Provincial Department of Health or in an agency of the Provincial government. Initially, some Provinces did utilize private insurance carriers for various administrative functions under the medical care plan. Such carriers were obligated under the terms of the Federal law to participate on a nonprofit basis as "designated agents" of the Provincial health authority. They were not allowed to assess or approve claims or to determine the amount of money to be paid with respect to claims. With the exception of Ontario and British Columbia, the Provinces generally opted for direct administration through a single public authority.

In Saskatchewan, approved nonprofit health agencies perform limited "post office" functions, receiving claims from medical members and passing on claims payments from the Provincial commission to physicians. In Nova Scotia, the medical insurance plan is operated by a conjoint public authority, consisting of the Provincial commission and Maritime Medical Care In., a doctor-sponsored prepayment agency authorized to act on a nonprofit basis as the fiscal agent of the public authority.

The British Columbia plan is marketed through two preexisting nonprofit plans (which are licensed to sell additional benefits over and above the basic Provincial plan, either separately or as a package connected with the governmental contract) and through the British Columbia Medical Plan, a governmental agency. The two nongovernment carriers limit their services under the plan to group coverage. Premiums collected by them on behalf of the governmental contract must be remitted to the Province and cannot be held in reserve. Carriers are responsible for enrolling residents, collecting premiums, and paying claims, but they do not assess or approve claims or determine amounts to be paid.

The situation in Ontario was somewhat unique. When the Province entered the medicare program on October 1, 1969, a majority of the residents were insured through more than 200 separate insuring agencies, each with its own administration and premium collection system. The Ontario government entered into an agreement with a consortium composed of 30 of the largest carriers, who were employed by the Provincial government as "designated agents." Private insurance firms which chose to participate in the Provincial plan were allowed to enroll their premedicare subscribers and to collect premiums on behalf of the Provincial plan. A government agency absorbed the subscribers of those carriers who were not interested in remaining in the field, as well as continuing to make coverage available to those who had been covered by the previous Provincial governmental plan, together with new pay-direct subscribers. Designated agents were responsible for enrollment, billing, and, in some cases, claims payment after certification by a Provincial official.

This operation continued for approximately two and one-half years and was phased out by April 1, 1972, at which time the Ontario Health Insurance Commission assumed responsibility for administration of both the hospital and medical insurance plans. The consortium arrangement had not proved effective in terms of economy of operation, uniformity of data collection, or continuity of coverage for enrollees changing from one to another carrier.

### REIMBURSEMENT METHODS

Since the fee-for-service method of payment had been the almost universal mode of physician-reimbursement prior to medicare, it was regarded as a logical arrangement for the new program. The Government of Canada acknowledged certain distinct advantages to this system, as noted below:

> * * * it enables governments to obtain, collate and analyze information about virtually every medical act rendered to a resident of Canada indicating what service was rendered, to whom, by whom, when, where and why, as a byproduct of the fee-for-service mechanism. The resulting data can be put to use in a variety of ways. For example, defects in the health system and deficiencies or surpluses in the availability of medical manpower are being identified, studied, and solutions sought. Many of these problems might otherwise have been ignored or remained ill-defined in the absence of data on medical care utilization being collected on a universal basis in each Province.[18]

An estimated 96 percent of total expenditures under the medical insurance program are currently made on the basis of fee-for-service, the remainder being paid to salaried physicians in organized clinic settings.[19] Generally, the bases for payments are the authorized fee schedules negotiated between the Provincial governmental authority and the Provincial medical association. In general, a physician has a choice 1) of dealing directly with the Provincial plan or its agents and accepting the plan's payment for his service (typically 85 to 90 percent of the fee schedule; Alberta and Quebec pay 100 percent of the fee schedule amount) as payment in full, or 2) "opting out" and dealing directly with his patient, who is then reimbursed by the Provincial agency only for the authorized amount and must make up from his own pocket any additional amount the "opted out" physician may charge. In one Province (Quebec), the physician who "extra-bills" is considered to be a "nonparticipating" physician, and the patient receives no reimbursement whatsoever for any services this category of physician may provide.

When the Province of Ontario first entered the Federal medicare program, it initially allowed physicians and other providers either to participate directly with the government for all insured patients, to participate on a patient-by-patient basis, or not to participate at all. Under these arrangements, the physician was allowed the following options with regard to reimbursement: (1) bill the government (or one of the approved private agents Ontario was using at that time for administration of the Provincial plan) directly for 90 percent of the amount set forth in the fee schedule negotiated between the Ontario Medical Association and the Provincial government, (2) bill the patient for the full amount of the physician's charge, in which case the government reimbursed the patient 90 percent of the approved fee schedule and the patient made up the difference, or (3) bill both the plan for its 90 percent of the fee schedule and the patient for any remaining charge the physician wished to impose.

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[18] "Questions and Answers: the Federal Medical Care Program." Minister of National Health and Welfare, Health Insurance Directorate, Health Programs Branch, Ottawa, 1974: 11.

[19] Taylor, pp. 36–37.

Beginning on January 1, 1972, however, the Provincial government required the physician to participate fully for all his insured patients or not at all. Under these circumstances, the provider is now required to accept 90 percent of the fee schedule from the government plan as full payment, with no "extra-billing" of the patient allowed, or he must bill all his patients directly. Estimates indicate that only about 9 to 10 percent of Ontario's physicians are currently not participating. It has been suggested that it is more in the physician's interest to be assured of 90 percent fee schedule reimbursement from the government than to rely upon reimbursement from the patient after the patient has received payment from the government agency. Another source has noted that:

> Obviously it is much simpler for each physician to send one statement to the government for all patients seen during the treatment period rather than to try to collect from hundreds of individual patients. Each physician participating in the Provincial plan regularly receives a lump sum payment, seldom has a bad debt, and is paid for virtually everybody he sees, and does not have the added expense of collecting his fees from individual patients.[20]

The following table presents the current situation regarding Canadian physicians who have opted-out of the medical insurance plans in the various Provinces.

*Current situation regarding opted-out physicians* [1]

| *Province* | *Situation* |
|---|---|
| Newfoundland | Four opted-out out of total of 500. |
| Nova Scotia | Extra-billing amounts to only 2.8 percent of plan payments. |
| New Brunswick | Four opted-out. |
| Prince Edward Island | None opted-out. Extra-billing less than one-half of 1 percent. |
| Quebec | Seven specialists opted-out. Three general practitioners opted-out (out of nearly 7,000 physicians). |
| Ontario | Nine percent opted-out. |
| Manitoba | Five percent opted-out. |
| Saskatchewan | Approximately 3 to 4 percent opted-out. |
| Alberta | None opted-out—can extra-bill under certain circumstances. |
| British Columbia | None opted-out. |

[1] LeClair, p. 55.

The following excerpt from a paper presented by the executive director of the British Columbia Medical Association provides an example of how one Province developed its methods of reimbursement and professional peer review over utilization of services:

> In our discussions in 1964 and 1965 prior to the introduction of the British Columbia medical plan, the association representatives tried to clarify certain points that were important in maintaining a healthy attitude of physicians toward whatever system developed

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[20] LeClair, p. 55.

because by and large physicians are suspicious and at times resentful of what appears to them to be government interference with their freedom to practice a high quality of medical care. There were two or three points that had to be made very clear and which took a lot of discussion in the early stages. One of these was opting out. It was felt that the physicians would not easily accept the idea that they must all be in the plan without any opportunity of maintaining their professional freedoms and working outside the plan if they so wished. The government, of course, wanted all physicians in because they felt that they were taking citizens' money, and if all doctors opted out in one town or in one speciality, then they would be accepting money for a service which they could not provide. They were most anxious to have no "opting out clause" in the agreement. The physicians were equally adamant that it was most important to allow physicians to opt out if they wished to. Otherwise a lot of good doctors would leave the Province. The association representatives said that the right to opt out was a very important right that should not be denied the physician. He should be able to practice inside the plan or outside the plan (if he could survive), as he so desired. It was also equally important that the patient should be able to go to a participating doctor or to a doctor who was outside the plan if the patient so desired. It was finally agreed that doctors could opt out without loss of benefits to insured persons. It might be interesting here to know that in the first two years of the plan, not one single doctor in British Columbia opted out. There is a recent example of a doctor who opted out on a Friday. When his patients came into his office on Saturday, he told them this and they said they would go to another physician. By Monday, he was back in the plan. Three plastic surgeons in Victoria have recently opted out, and it will be interesting to see what results from this action.

Another important facet of the plan was how fee schedules would be arranged. It was agreed that the writing of the fee schedule and the determination of the amounts to be paid for certain procedures was the association's business. It was also agreed that the overall cost was a matter of interest to both the profession and the government. It was therefore agreed that at periodic intervals the profession and the government would discuss the overall cost and then the details of the fee schedule would be worked out by the profession within the range of the agreed upon increase—or change in the overall cost. At this time, for the first time anywhere, indexes were used as a guide, and the profession tied itself to two indexes to be used in the amount of change in the overall cost of the plan. After lengthy discussion regarding disposable income index—cost of living, wages and salaries indexes, and so forth—the cost of living index for the city of Vancouver and the wages and salaries index for the Province of British Columbia were used with equal weighting in the determination of a joint index that was used to provide the overall cost of changes in the fee schedule. At the time that this was discussed, some five years ago, the average of the two indexes together was running about 2½ to 3 percent per year, and it was finally agreed that 2.75 percent per annum would be taken as an automatic increase providing the indexes rose that much, and if they went more than that then we would negotiate and take into account any other factors in the economy which might be playing a part in doctors' costs and incomes. We also agreed that if the joint indexes rose to more than eight percent, that either side could ask for compulsory arbitration. We have had two negotiations under this formula, which have worked very well. The signed agreement was for a five-year term, which runs out at the end of this year. It is very obvious that some arrangement with regard to changing fees must be made because the profession cannot be put in the position of going

> with their hat in their hand and asking for more money at regular intervals, and the government always has some other areas that need available money. This is why a written agreement covering these points is essential. Our agreement is what makes these points clear and makes the cooperation possible.
>
> Another point that was felt necessary for the profession to be content with the scheme was the point of "extra-billing." After much discussion it was agreed that there were times when extra-billing should be allowed—if the patient demands Cadillac care instead of the regular model Ford that is being offered this year, he should be prepared to pay a little more. It was agreed that extra-billing could be allowed provided the doctor made an arrangement with the patient before he started care, and it was agreed that this arrangement with the patient would be in writing so that there would be no misunderstanding. So that we all understand what we are talking about, we should realize that extra-billing means a charge over and above the current agreed minimum fee schedule. The plan does not pay for this as they pay the current fee schedule on a 90 percent basis only.
>
> Another point clarified was discipline of physicians. It was also agreed that the public purse must be protected against those few members of the profession who sometimes appear to abuse it. At the same time, we agreed that the government should not be the body to discipline the profession as they cannot do it nearly as well as the profession itself, if they are willing to do it. Therefore, it was decided that any abuses by the profession should be referred to the British Columbia Medical Association for appropriate action. This is a most important point, and it is essential for the government to obtain the cooperation of the profession in matters of this kind. It is equally essential for the profession to maintain its own internal discipline. In British Columbia every patient receives a copy of every bill submitted by the doctor for his care, and of every payment made to the doctor for this care. This is the stage at which most of the few irregularities are spotted, and it is easy to do with modern computer and the techniques employed by the plans in administering accounts. By the computer it is possible to produce patterns of practice of doctors involving their utilization of services and the amounts of money and the numbers of times the patients are recalled, laboratory services, etc.
>
> There is a pattern of practice profile kept on every doctor, to compare him with his fellows in the same type of community and carrying on the same type of practice. You can get a pretty good idea of what the norm is and should be. If there is a variation of more than two standard deviations a committee of the association looks at the profiles and may interview the doctors concerned, and the appropriate action is recommended. We also have other committees which really do what is commonly referred to as a "peer review," such as Reference Committee, Cost Quality Study Committee, and so forth.[21]

Prior to implementation of the medical insurance program, opponents of medicare had warned that Canadian doctors were likely to find practice more attractive and lucrative in other countries, particularly the United States, and that the country's less than optimum physician-per-population ratio of 1 per 763 in 1966 would suffer as a result of a massive physician-emigration. Statistics from the Canadian Department of National Health and Welfare appear to dispel this fear—in 1973, the ratio had improved to 1 doctor for every 633 Canadians, partly through a marked reduction in the number of Canadian-born physicians emigrating to the United States and partly through a doubling of the number of physicians and surgeons immigrating to Canada since enactment of medicare.

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[21] E. C. McCoy, M.D., Executive Director, British Columbia Medical Association, "History of the Development of the Health Care Program in British Columbia, Particularly Related to Physicians' Services." In "National Health Care: the British Columbia Experience," Office of Comprehensive Health Planning, Olympia, Wash., 1971.

Canada has experienced, however, a chronic problem with maldistribution of medical personnel, particularly in its sparsely populated rural and northern regions. Over one-third of Canada's active physicians are located in Ontario, which had a ratio of one doctor for every 616 persons in 1971; by way of contrast, Prince Edward Island had 1 doctor per 1,143 persons. Maldistribution has been eased somewhat in recent years, due in part to special financial incentives offered by some Provinces to persuade doctors to locate in underserved areas and partly through equalization of the economic differential between less or more wealthy Provinces through elimination of bad debts. Newfoundland, for example, has experienced a 250 percent improvement in its physician: population ratio from 1:1,467 in 1968 to 1:1,090 in 1971.[22]

There have been reports that increasing numbers of doctors in several Provinces have been threatening to opt-out of Medicare if their fee schedules are not raised. Yet doctors still rank as Canada's highest paid category of workers and reportedly make only slightly less than five times the amount of the average Canadian wage earner.

In the 10-year period between 1959 and 1969, Canadian doctors more than doubled their gross and net earnings from fees, while holding their expenses to a lesser increase. Average gross earnings for physicians in 1969 climbed to $46,328, up from $22,910 in 1959. Average net earnings rose to $30,861 in 1969, compared with $14,590 ten years earlier. The 10-year average increase in average net and average gross earnings was 7.8 percent and 7.3 percent, respectively. According to an analysis of 1973 Federal income tax returns, the average self-employed doctor earned $42,730 in that year, substantially more than the next highest contender—lawyers at $36,598 a year. Between 1968 and 1973, the average doctor's income is reported to have climbed by 46 percent, while his average tax payment increased by only 20 percent.[23] The following table gives the average net earnings of fee-for-service physicians in Canada from 1963 through 1974 (preliminary estimates only):

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[22] "Questions and Answers: the Federal Medical Care Act," p. 12.

[23] "Canada: Physician Income." Medical Care Review, January 1976: 59–60.

*Average net professional earnings*[1] *of active fee practice physicians, Canada, by Province, 1963 to 1974*

| Province | 1963 | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970[2] | 1971[2] | 1972[2] | Preliminary estimate[3] | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | 1973 | 1974 |
| Newfoundland | $19, 455 | $21, 523 | $23, 028 | $23, 304 | $25, 578 | $30, 488 | $37, 817 | $41, 562 | $38, 846 | $38, 282 | $42, 800 | $45, 300 |
| Prince Edward Island | 15, 777 | 16, 478 | 17, 835 | 18, 910 | 20, 716 | 22, 636 | 22, 760 | 26, 892 | 38, 822 | 37, 687 | 37, 500 | 42, 500 |
| Nova Scotia | 14, 839 | 17, 851 | 19, 146 | 20, 395 | 21, 480 | 24, 642 | 29, 880 | 35, 776 | 35, 351 | 37, 715 | 37, 600 | 40, 100 |
| New Brunswick | 17, 701 | 19, 255 | 20, 251 | 20, 807 | 24, 662 | 27, 544 | 29, 678 | 33, 083 | 39, 944 | 43, 012 | 41, 100 | 42, 500 |
| Quebec | 16, 696 | 18, 534 | 20, 532 | 21, 231 | 23, 133 | 25, 112 | 27, 233 | 27, 402 | 41, 131 | 43, 401 | 44, 400 | 45, 200 |
| Ontario | 20, 492 | 22, 247 | 24, 188 | 23, 456 | 29, 354 | 32, 098 | 33, 903 | 38, 993 | 41, 363 | 40, 968 | 39, 400 | 42, 500 |
| Manitoba | 18, 178 | 18, 720 | 19, 681 | 21, 565 | 23, 229 | 26, 108 | 31, 678 | 38, 657 | 38, 803 | 35, 545 | 34, 400 | 35, 000 |
| Saskatchewan | 21, 625 | 23, 879 | 23, 530 | 24, 274 | 24, 697 | 25, 175 | 27, 657 | 31, 288 | 32, 314 | 34, 889 | 34, 300 | 35, 700 |
| Alberta | 19, 111 | 21, 117 | 22, 681 | 24, 356 | 27, 591 | 33, 221 | 33, 165 | 39, 678 | 40, 357 | 39, 687 | 36, 500 | 35, 900 |
| British Columbia | 17, 464 | 19, 560 | 20, 121 | 22, 209 | 25, 169 | 26, 239 | 28, 829 | 31, 006 | 31, 138 | 32, 991 | 35, 200 | 40, 300 |
| Yukon and Northwest Territories[4] | 16, 480 | 13, 601 | 15, 731 | 13, 039 | 13, 220 | 18, 000 | 15, 807 | 17, 262 | 21, 610 | 25, 691 | NA | NA |
| Canada | 18, 688 | 20, 484 | 22, 064 | 23, 262 | 26, 093 | 28, 615 | 30, 861 | 34, 360 | 39, 203 | 39, 978 | 39, 600 | 42, 200 |

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[1] Includes net professional fees (i.e., gross receipts minus expenses of practice), and earnings received in the form of wages and salaries incidental to professional practice.

[2] Excludes earnings of some salaried physicians in active practice.

[3] Estimates largely based upon changes in fee payments made by Provincial medical care insurance programs and, upon estimated changes in expenses of practice, taking into account recent increases in relevant price and wage levels.

[4] Data to 1968 for the Yukon and Northwest Territories are posetd for record only.

NOTE.—Preliminary review of data for 1973 just received from Revenue Canada suggests that expenses of practice increased less than estimated, and that net income in 1973 tended to be slightly higher than is shown in the table. The data indicate that for Canada as a whole net incomes in 1973 were about 2 to 3 percent higher than in 1972.

Source: Revenue Canada, unpublished statistics.

## RISING COSTS

Over the decade of the 1960s, Canadian expenditures for all types of health care more than tripled. Year-to-year percentage increases from 1960 to 1970 were never below 8 percent. National health expenditures as a proportion of the GNP rose from 3.8 percent in 1960 to 7.1 percent by 1971. The Federal share in total national health expenditures rose from 27.1 percent in 1966 to 33.0 percent in 1971. Per capita spending on health care reached $306.11 in 1971, representing 9 percent of disposable net personal income. It has been estimated that by 1980, health care expenditures in Canada will represent 9.1 percent of the GNP, or 13.3 percent of disposable net personal income.[24]

Until fiscal year 1974–75, actual combined costs—both Federal and Provincial—for the insured services of the hospital and medical insurance programs were lower than estimated costs. Since 1974, however, estimates have been outstripped by actual cost experience. For fiscal year 1975–76, it is estimated that combined Federal/Provincial expenditures for both the hospital and medical insurance plans will exceed $6 billion. In fiscal year 1974–75, Federal costs alone ran over $2.7 billion, up 19.8 percent from the previous year.[25]

Year to year increases in hospital costs have been far more of a problem than annual increases in medical costs. In fiscal year 1974–75, the costs of insured hospital services went up 25.5 percent over the previous year, as compared with a 6.5 percent increase in the costs for insured medical services for the same year. Per capita costs for insured hospital services reached $175.10 in fiscal year 1974–75, with medical services costing $64.98 per person. In fiscal year 1974–75, British Columbia and Ontario registered the greatest percentage increase in Provincial hospital costs over the previous year (39.2 percent and 31.6 percent, respectively), while the Northwest Territories and Prince Edward Island led the Provinces in increased costs of insured medical services (50.3 percent and 20.5 percent, respectively).[26]

Per capita hospital operating expenditures in Canada rose from $38.14 in 1961, to $105.64 in 1970 and $127.78 in 1972. Hospital operating costs per patient day rose from $23.01 in 1961 to $56.27 in 1970 and $68.74 in 1972.[27] In an attempt to deal with the problem of ever-inflating hospital costs, many Provinces have imposed ceilings on the percentage of increased allowed to hospitals over their previous year's net base operating expense—5 percent being the most common percentage increase allowed by most Provincial hospital authorities. Some Provinces are actually decommissioning many active-treatment beds and some small rural hospitals in an attempt to reach a lower bed-per-population ratio (the desired goal reported to be 4 to 4.5 beds per 1,000). Such efforts have met with resistance in certain areas where alternative facilities are remote from the local area or where the decommissioned facility has provided a substantial source of employment and economic support for the community.

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[24] Andreopoulos, p. 2.

[25] Unpublished Canadian Government data from June 1975 budget excerpt regarding health care services.

[26] Ibid., financial and statistical tables.

[27] Annual Report 1973–74 on Hospital Insurance and Diagnostic Services Act, pp. 64–65.

Ninety-three percent of the Canadian hospital beds are in public hospitals most of which are privately operated but dependent on public sources for most of their operating revenues. In 1972, Canada had 1,276 hospitals with a total of 150,043 beds. (These figures include only hospitals listed under agreements for purposes of the Hospital Insurance and Diagnostic Services Act, and exclude facilities which are mental hospitals, tuberculosis sanatoria, or custodial or domiciliary institutions.) The short-term hospital bed-per-population ratio in 1972 was 5.5 per 1,000 population; if long-term beds in listed hospitals are included, the ratio was 6.9 per 1,000 population.[28]

Not only does Canada have far more hospital beds per population than the United States (which registered about 5 beds per 1,000 population for the comparable time period), but it also makes greater use of those beds as indicated in comparative hospital utilization statistics for the two countries. In 1972, hospitals in Canada registered an admissions rate of 168.9 per 1,000 population, up from 157.7 in 1961; data for the United States in 1972 showed an admissions rate of 148.3 per 1,000 population. In 1972, Canada experienced the shortest average length of stay—11.7 days—of any year since 1961; in the United States, average length of hospital stay has never, in any year since 1961, exceeded 9.1 days with the average for 1972 set at 8.4 days. Canada has traditionally reported a higher overall hospital occupancy rate than in the United States—in 1972, Canada's rate of 80 percent reflected an actual decrease of 1.8 percent from the 1971 rate, whereas the current U.S. rate is about 75 percent.[29]

While the rate of increase in medical expenditures has not equaled that associated with hospital care, there is concern nonetheless that total expenditures on insured physicians' services under medicare have continued to rise steadily throughout Canada regardless of whether physicians' fees have actually risen. The connection between fee increases and total program expenditures is obvious, but various studies on the Canadian program have shown that the absence of such fee increases has not inhibited overall growth rates. Elimination of bad debts and greater adherence to fee schedule amounts (rather than reduction or waiver of such amounts for poor patients) are assumed to have had an initial impact on increasing program expenditures for physicians' services. Yet, relative price increases in the medical care industry have actually slowed down since medicare went into effect and program expenditures for physicians' services have nonetheless continued to climb. On an annual per capita basis, the rate of increase in medical costs is currently almost one-third less than it was in the several years leading up to medicare.[30]

Nor can increased expenditures be directly attributed to significant increases in patient utilization of services. As one author has observed:

> The before-and-after medicare study of physician utilization in Montreal reports that aggregate visit rates did not rise in response to insurance and that physician hours of work did not increase. Instead, physicians reorganized their practice patterns and generated more income from a given number of initial patient contacts. This is supported by data from Trans-Canada Medical Plans showing that in

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[28] Annual Report 1973–74 on Hospital Insurance and Diagnostic Services Act, pp. 19–22.

[29] Ibid, pp. 22–25.

[30] LeClair, p. 48.

> insured populations, rates of physician-generated services per capita tend to rise faster over time and to be more closely associated with physician availability than are rates of patient-generated services * * * Rather than having physician expense driven by independent shifts in demand, we seem to be observing a linkage between supply of physicians and the quantity of services they choose to perform to total expense.[31]

The author concludes that "efforts to modify patterns of expenditures by incentives directed at the consumer of care cannot hope to influence overall cost trends," and that official attention will probably be directed at approaches which will alter the existing structure of medical practice, e.g., through such vehicles as restriction of physician immigration, public ownership and operation of facilities, employment of physician-personnel in networks of Community Health Centers, unilateral government determination of fee schedules or absolute limits on physician earnings, more intensive scrutiny and utilization of the physician profiles described in the reimbursement section, etc.[32]

In its June 1975 budget message, the Canadian Government announced the introduction of two measures designed to restrain future program cost increases at the Federal level and to spur initiative at the Provincial level to formulate more effective cost control mechanisms. With regard to the hospital insurance program, Ottawa gave formal notification of its intention to renegotiate in 5-years time the basis of Federal financial participation with the Provinces. Secondly, it announced the imposition of a ceiling on the annual percentage increase which would be allowed with regard to the amount of Federal contributions to the Provinces for insured medical services. For fiscal year 1976–77, the ceiling would initially be set at 13 percent (apart from those expenditures attributable to population growth), with a 10.5 percent maximum increase allowed for fiscal year 1977–78, and 8.5 percent for fiscal 1978–79 and thereafter.

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[31] Robert G. Evans, "Beyond the Medical Marketplace: Expenditure, Utilization, and Pricing of Insured Health in Canada," in National Health Insurance: Can We Learn from Canada? ed. by Spyros Andreopoulos. John Wiley and Sons, New York, 1975: 159–162.

[32] Ibid.

# Appendix I

## COMPARISON OF PROVINCIAL HOSPITAL PLANS

The following is a brief description of changes that have occurred in the provincial hospital plans during the past two years. (See the comparative tables for details.)

### BRITISH COLUMBIA

A cytology service is universally available for residents of the Province.

Day-care, night-care, and certain out-patient psychiatric services, as insured benefits, are available at selected hospitals.

Day-care rehabilitative services are offered at the G. F. Strong Rehabilitation Centre in Vancouver.

Out-patient physiotherapy treatment provided in those general and rehabilitative hospitals having the necessary facilities.

Diabetic day-care services available in certain designated hospitals.

A beneficiary is required to pay a nominal sum for each visit to the hospital for the above-mentioned services, and the remainder of the cost is paid by the British Columbia Hospital insurance service.

Coverage has also been extended for the treatment on an out-patient basis for narcotic addiction at the Narcotic Addiction Foundation in Vancouver.

### ALBERTA

Effective as of January 1, 1973, all approved operating costs of hospitals are paid 100% by the Province.

### SASKATCHEWAN

Effective January 1, 1972, residents 65 years or over were granted free medical and hospital care. Effective January 1, 1973, resident treaty Indians within the meaning of the Indian Act (Canada) became entitled to medical and hospital coverage without reference to tax payment. Effective January 1, 1974; residents are entitled to health care coverage without payment of a tax or premium.

### MANITOBA

The hospital and medical insurance programs have been administered by one authority, the Manitoba Health Services Commission, since October, 1970.

### ONTARIO

Effective April 1, 1972, hospital and medical insurance plans combined as one Ontario Health Insurance Plan operated by the Ministry of Health. There is a combined annual premium of $132 single, and $264 family. No premiums payable by persons aged 65 or over who have been Ontario residents one year or more. Premium assistance available, based on taxable income, to persons who have been Ontario residents for 12 months or more. Temporary premium assistance is available for persons temporarily unable to pay for coverage.

Plan includes hospital, extended nursing care, ambulance, medical and specified in-hospital dental benefits; plus allowances for eye examination by optometrists and services of chiropractors, osteopaths and chiropodists (podiatrists).

On September 1, 1973, responsibility for nursing education was transferred from hospital nursing schools under the Ministry of Health to the Ministry of Colleges and Universities.

### QUEBEC

The major change that has occurred in Quebec is the transfer of responsibility for the administration of the plan to the Department of Social Affairs.

All hospital services insured in Quebec but received in another Canadian province are reimbursed at the prevailing tariff. Under certain conditions, this may apply to services given outside Canada.

### NEW BRUNSWICK

Out-patient benefits and out-of-Province benefits are given in more detail. Method of hospital payments; inpatient, paid in 24 semi-monthly fixed payments. Out-patient, paid semi-monthly rather than monthly.

### NOVA SCOTIA

Hospital Insurance Commission and Medical Insurance Commission merged September 1, 1973, to become Health Services and Insurance Commission.

### PRINCE EDWARD ISLAND

No significant change.

### NEWFOUNDLAND

No significant change.

### NORTHWEST TERRITORIES

No significant change.

### YUKON

No significant change.

| | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario |
|---|---|---|---|---|---|
| Capital financing | 60 percent of net approved cost of construction after deducting Federal grants, rising to 80 percent of that portion, if any, resulting in regional district property tax rates exceeding 4 mills in any year for approved hospital construction; ⅓ approved cost of depreciable furnishings and equipment (including improvements). Per diem equipment allowance included in operating budget. | Construction costs are met either by outright payment or by payment of interest and principal instalments on debentures. | New construction and renovations—Based on share percentage of the approved construction budget. Eligible grants—Base hospital—60 percent Regional hospital—50 percent. Community hospital—40 percent. Projects under $10,000 would not be eligible unless it can be demonstrated that operating efficiencies and cost savings would result. | 20 percent of the cost of new hospital construction or major renovations is the responsibility of the owner. The balance of the cost is financed through approved borrowing and is repaid (including interest) from allowances provided by the Commission through operating budgets. | Capital financial assistance provided for ⅔ of approved cost of community hospitals; full cost of university hospitals, and teaching and research components of university-affiliated hospitals; also, for regional rehabilitation hospitals. |
| Administration | A branch of Department of Health administered by a deputy minister. Divisions: Finance, Consultation, and Inspection, Construction, Medical Consultation, Research, Office of Administrative Officer. | Constructions, renovations, equipment services, inspection, statistics, and finance are administered by the Alberta Hospital Services Commission. | Administered by the Saskatchewan hospital services plan, which is a branch of the Department of Public Health, Divisions are Programs and Standards, Finance and Statistics, Registration and Benefits, Construction, and Administrative Services. | The Manitoba Health Services Commission a 9 man Commission reporting to the Minister of Health and Social Development, administers both the hospital and medical insurance programs. An executive director is the chief executive officer responsible for the day-to-day administration of the plan. | 1. As of Apr. 1, 1972, capital financing administered by Ministry of Health.<br>2. Ontario health insurance administered by a division of the Ministry. |
| Benefits | Inpatients: Standard ward, all approved and available services. Outpatients: Emergency services. Minor surgical procedure. Day-care surgical services. Outpatient cancer therapy, extended care. Activation/rehabilitation. Outpatient physiotherapy treatment. Diabetic day-care services. | Inpatients: Standard ward and all approved and available services. Outpatients: 100 percent of all procedures listed in the approved schedule of outpatient services. 100 percent of diagnostic and physiotherapy services outside hospitals listed in the above schedule. | Inpatients: Standard ward, all available and approved services. Outpatient: to the extent that a hospital is able to provide it. | (I) Persons leaving Manitoba permanently may apply for an out-of-Province certificate and receive benefits to the last day of the 2d month following arrival in new place of residence. (II) Temporary absence for up to 12 mo permitted without loss of coverage. | Inpatient: Standard ward and all approved and available services. Outpatient: Broad range of essential services, physio-occupational, speech, radio- and inhalation-therapies and other hospital services when medically necessary. Also insured: essential ambulance service (see Authorized Charges), home dialysis and private physiotherapy. |

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| Waiting period | Eligible 1st day of 3d month following month of arrival. | None | For most new residents to the 1st day of the 3d month following the date of establishing residence. Special arrangements available to persons who are landed immigrants, members of the Canadian Forces, and returning Canadian citizens. | 1st day of 3d month after arrival for persons from other provinces. If previously resident outside Canada, benefits are available on the date of arrival. | 3 mo. |
| Out-of-Province benefits | (a) Inpatient within 1st 12 mo of temporary absence from province for a maximum stay of 12 mo unless otherwise approved; (b) referral, of approved by Deputy Minister. | 100 percent of all procedures listed in the approved schedule of outpatient charges. 100 percent of all approved inpatient charges. | Within Canada—Inpatient: standard ward rate less co-insurance where applicable. Outpatient: 100 percent of bill. Outside Canada—Inpatient: maximums apply as to rate and volume. Outpatient: maximum applies as to rate. | In Canada: In accordance with rates approved by the provincial insurance plan of the province in which hospitalization occur. Outside Canada: The benefits payable are the greater of 75 percent of the hospital's charges for insured services or an approved daily allowance if care and treatment is required as a result of an emergency or medical referral. In elective cases, the benefits payable are the lesser of 75 percent of the hospital's charges for insured services or an approved daily allowance. | Full rate in other Canadian Provinces less any co-insurance or capital charges made by province concerned. 75 percent of standard ward for elective admissions in the United States including room, board and all insured extras. 100 percent of accidents anywhere in the world 100 percent of standard ward care in all other cases occurring outside Canada or the United States. |
| Method of Provincial financing. | Consolidated revenue | General revenue | Grants from consolidated revenue. | General revenues of the Province. | Hospital and medical benefits financed by: (i) Consolidated revenue, and (ii) Premium: $132 per year single, $264 per year family. Balance, up to Federal contributions, paid from consolidated revenues. No premiums for residents of 1 yr or longer aged 65 plus; premium assistance available for others based on taxable income. Also temporary premium assistance. |

| | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario |
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| Authorized charges | (i) $1 per day for standard ward care; (ii) $2 for each emergency or minor surgical outpatient treatment; (iii) $2 for day-care surgical services; (iv) $1 for outpatient cancer therapy. | Adults—$5.00 for the 1st day. Auxiliary hospitals: $3.00 per day after 120 days. | Nil | Hospitals may charge $6.00 per day for semi-private wards (varying amounts for private accommodation). | None—except for insured ambulance services. Patient pays $5 per land trip up to 25 miles and 15 cents per additional mile to a total of $25. Authorized air ambulance charge is $25 including connecting land ambulances. |
| Method of hospital payments. | By semimonthly payments, service pays hospitals each month approximately 1/12 of yearly approved budget as represented by B.C.H.I.S. insured days. | The hospitals receive monthly payments on account of the total amount for the year. The monthly payments are based on a budget submitted by the hospitals. | Inpatients: Fixed semimonthly payments based on approved expense budget, less offset revenue. Outpatients: Fixed semimonthly payments established to meet estimated direct costs. | (i) 24 semimonthly payments based on Net Approved Budget including interest on allowable capital debt and depreciation on buildings. | Total approved expense budget less cash revenues, less half differential revenue divided by estimated patient-days to obtain a tentative approved per diem rate. Standard ward level costs paid to hospitals on an interim bulk payment plan with year end settlement. |
| Adjustments of hospital payments. | Under firm budget procedure. Adjustments made for fluctuation in days, etc. Budgets increased (decreased) by days difference times patient-day value of variable supplies. Additional adjustments made where large fluctuations in occupancy affect standing costs. | Effective as of Jan. 1, 1973, all approved operating costs of hospitals are paid 100 percent by the Province. | Rates may be adjusted during the year for changes in volumes and standards of care. Final settlement may be made after yearend, following review of audited financial statements. Surpluses at yearend, resulting from efficiencies in operation, are retained in part by hospitals according to predetermined formulae. | Although legislation provides for retroactive adjustments following the yearend, hospitals are encouraged to live within the approved budget or face the possibility of financing expenditures over the budget. | Renegotiated during year when material fluctuations present in patient days, etc. Final settlement upon review of audited yearend statements. |
| Depreciation on buildings and interest on capital debt. | Not allowable (on capital and current debt). | Depreciation on buildings not allowable. Repayment of debentures and interest on capital debt is paid by the Province. | Not allowable | Allowable on buildings (depending upon type of construction) and approved equipment (6¼ percent). Interest on approved debentures, allowable. | Not allowable. |

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| **Outpatient revenue** | Deducted from budgeted cost before reimbursible rate is calculated. Allowance made for uncollectible outpatient charges where adequate procedures have been followed by hospital. | The Province pays for 100 percent of all procedures listed in the Approved Schedule of Out-Patient Services and 100 percent of diagnostic and physiotherapy services outside hospitals. | Deducted from budgeted cost before reimbursible rate is calculated. | Deducted from budgeted cost before reimbursible rate is calculated. | Amount remaining after subtracting allowances made for courtesy care from gross outpatient earnings is deducted from cost. No deduction from gross earnings is allowed for bad debts or free work. |
| **Differential charges** | Hospitals retain 40 percent of room differential. | Differential charges are treated as offset revenue. | Hospitals retain 50 percent of room differential. | Hospitals retain 20 percent of room differential. Patient responsible for extra charge for private or semiprivate accommodation. | Hospitals retain 50 percent of the revenue, less bad debts in respect of preferred accommodation. Other 50 percent deducted from allowable exemption. |
| **Indigent payments** | Allowance made for uncollectable accounts. Where indigent is under Social Welfare, Provincial Government pays $1 per day in-patient charge or $2 minor surgery outpatient charge. Also $2 charge for day care surgical services and $1 for outpatient cancer therapy, outpatient physiotherapy, diabetic daycare services, outpatient psychiatric services. | No special payments for indigent accounts. Loss of revenue due to uncollectable accounts related to standard ward care is paid by the Province. | The Saskatchewan assistance plan provides assistance to residents who are in need. Persons who are nominated under the assistance program for hospital care coverage become beneficiaries of the Saskatchewan hospital services plan. | Insured services: Municipalities pay premiums that are in arrears for more than 30 days. Noninsured Services: Municipalities pay indigent accounts for legal residents at rates established by the Commission. | Province pays premium for Provincial welfare cases (blind, mother's allowance, etc.). Municipalities insure all their qualified welfare recipients without payment of premium. |
| **Controls** | Admission sheet and long stay (30 days) form required on each patient to substantiate that hospitalization is medically necessary. An extensive medical assessment of claims is carried out along with a quarterly assessment of continued medical eligibility for extended care. Budget must be approved by rate board. Monthly and annual operating statements are submitted to plan. Officers of B.C.H.I.S. inspect accounts and operations of the hospital by regular visits. | An admission sheet is required on each patient to substantiate that hospitalization is medically necessary. Payments to hospitals are based on budget submitted by the hospital. | Admission sheet and long stay (30 days) report required on each inpatient to substantiate that hospitalization is medically necessary. Reports identifying beneficiaries and services provided required for outpatient care. Budgets, monthly reports and auditors' annual financial statements submitted to the plan. General criteria and maximum costs for approved volumes of services established by the plan. Inspections covering administration, finance and standards carried out by plan officials. | Admission/separation report and long stay (30 days) form required on each patient to substantiate that hospitalization is medically necessary. Budget must be approved by Commission. Detailed quarterly, and annual operating statements must be submitted to Commission. Accounts and operations of the hospital are inspected by plan officials. | Admission sheet and long stay (30 days) form to substantiate confinement medically necessary. Budget approved at year's beginning. Items may be disallowed by hospital budget committee. Monthly and annual operating statements provided to plan, hospital experience used as yardstick in evaluating budget, actual costs, sundry revenue. Officers of plan inspect hospital accounts and operations. |

| | Quebec | New Brunswick | Nova Scotia | Prince Edward Island | Newfoundland |
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| **Capital financing** | No capital grants regulations. If approval for construction is received from provincial government, there are grants matching the Federal contribution and, if required, may go higher. | 100 percent of costs paid by Province. | Provision of grants and other assistance of up to 80 percent of approved construction costs (effective Apr. 1, 1973). | $6,000 per bed or bed equivalent, plus 50 percent of the balance of cost after grant. 83⅓ percent of cost of renovations. | Province makes substantial grants towards capital costs. Approved equipment financed through hospital insurance on an "out-right purchase" basis. |
| **Administration** | Ministry of Social Affairs | Hospital Services Division of Department of Health. Consulting staff consisting of 2 consultants in hospital administration, one consultant in each of: nursing, X-ray, pharmacy, purchasing (equipment, plant operation and maintenance). Hospital Standards Committee consisting of 5 members representing Medical society and hospital boards, together with designated officials from Department of Health. | Hospital Insurance Commission and Medical Insurance Commission merged Sept. 1, 1973. to become Health Services and insurance Commission responsible for both federally shared medical care and hospital insurance programs. Also responsible for provincially financed psychiatric hospital program and, as of Nov. 1, 1973, for the Mental health clinic program. | Commission has 4 divisions—Eligibility, claims and 3d Party Liability Standards and Administration, Accounting and Finance, Medical Assessment. | Program administered as Division of Department of Health. Consulting services available on request. |
| **Benefits** | Inpatients: Standard ward and all approved available services. Outpatients: (a) certain psychiatric services, (b) emergency (24 hours), (c) minor surgery including X-ray and laboratory examinations and related interpretation, (d) physiotherapy, (e) radiotherapy, (f) medical orthoptics, (g) occupational therapy, (h) audiology and speech therapy. | Inpatients: Standard ward, all approved available services. Outpatients: All approved available services except visits for injection only. | Inpatients: Standard ward, all approved available services. Outpatients: (i) medically necessary diagnostic radiological examinations with necessary interpretations, (ii) specified laboratory examinations, (iii) radiotherapy where available, (iv) tumor clinic services, (v) blood, including fractions, (vi) minor medical and surgical procedures, (vii) ECG's and EEG's where available, (viii) physiotherapy where | Inpatients: Standard ward, all approved available services. Outpatients: (i) laboratory procedures, as specified, (ii) radiological procedures, as specified, including use of radioactive isotopes, (iii) drugs, biological and related preparation for emergency diagnosis and treatment, (iv) all other services specified as inpatient services. | Inpatients: Standard ward, all approved available services. Outpatients: (i) laboratory, (ii) radiotherapy and physiotherapy, where available, (iii) occupational therapy, where available, (iv) outpatients visits, emergency visits, operating room facilities including supplies, plaster casts, drugs and medical and surgical supplies administered in hospital. |

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| | | | available, (ix) drugs, biologicals and repeated preparations when administered in a hospital, (x) hemo dialysis, (xi) inhalation therapy, (xii) intermittent positive pressure breathing, (xiii) ultrasonic diagnostic procedures, (xiv) diagnostic procedures involving radioactive isotopes. | | |
| Waiting period | 3 mos | Eligibility begins on the 1st day of the 3d month following establishing residence in the province. | 1st day of 3d month following arrival from elsewhere in Canada. 1st day coverage for persons moving to Canada from outside. | 60 to 90 days | 1st day of 3d month after arrival for persons from other provinces. If previously resident outside Canada, benefits are available on the date of arrival. |
| Out-of-Province benefits | Plan pays full approved rates for insured services provided in other provinces. Up to $25 per day for adults and children and $5 per day for newborns outside Canada.<br>Under certain conditions, the same principle applies outside Canada. In other cases, up to $25.00 per day. | In Canada: complete inpatient coverage at standard ward rate and outpatient services at New Brunswick rates during periods of temporary absence and up to 3 mo following a move to another province. Outside Canada: Inpatient coverage up to a maximum charge of $65 per day. Outpatient services for emergency diagnosis and treatment of an injury if treated within 48 hr of being injured. | (a) Emergency, (b) approved by Commission. In-patient care only paid at the full ward rate in Canada and outside of Canada raised from $70 per diem to $100 plus 75 percent of any additional approved costs. | (a) Emergency, (b) With approval of Commission. Inpatient and outpatient services. | (i) During temporary absences, same as provided in province.<br>(ii) If a person leaves the province but remains in Canada, coverage ends the last day of the 2d month following month of arrival in the new province. Outside Canada coverage ceases as of the date of leaving the country. |
| Method of Provincial financing. | General revenue | Consolidated revenue | Consolidated revenue. 7 percent health services tax. | Consolidated revenue | Consolidated revenue. |
| Authorized charges | When admitted to a ward, no charge to patient. However, patient responsible for the differential charge for occupation of a private or semiprivate room, also for a standard room in a prolonged-care hospital. | None | None | None | None. |

| | Quebec | New Brunswick | Nova Scotia | Prince Edward Island | Newfoundland |
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| Method of hospital payments. | 26 payments per year based on approved expense budget (net of offset revenue). Outright purchase reimbursement on equipment paid on quarterly basis effective Jan. 1, 1967. | Inpatient: Approved Budget paid in 24 semimonthly fixed payments. Final settlement made after determination of year's costs. Outpatient; Paid semimonthly on the basis of an approved budget related to an estimate of the volume of service. Equipment: Approved budget paid on submission of invoices for purchases. | Approved budget paid in 24 semimonthly instalments. Depreciation on major equipment paid semiannually. | Approved budget paid in 24 semi-monthly instalments. | Approved budget paid in 12 monthly instalments, less holdback to determination of year's costs. |
| Adjustments of hospital payments. | Appeal may be made against approved budget between June 1 and October 31. A deficit adjustment may be applied for after audited financial statements are prepared. Revisions may be made only when due to circumstances beyond our control. | Rates may be adjusted during year if necessary. Final review and adjustment made at yearend when audited statements available. | Hospital or Commission may request budget review after June 1. Final review and adjustment made after yearend when audited statements available. | Hospital or Commission may request budget review after June 1. Final review and adjustments made after yearend when audited statements available. | Rates may be adjusted during year if necessary. Final review and adjustment made at yearend when audited statements available. |
| Depreciation on buildings and interest on capital debt. | Not allowable | Designated capital debt, principal and interest, paid on maturity date. All new construction and major renovations paid by Province on submission of architect's certificate, and authorization of project manager where applicable. | As part of the construction grant program, assistance is provided for the payment of both principals and interest on approved capital debt. | Not allowable | Not allowable. |
| Outpatient revenue | Clinic fees and revenue from organized outpatient services are retained by the hospital. | Deducted from budget cost before reimbursable rate is calculated. Net earnings deducted and allowance is made for bad debts. | Deducted from budgeted cost before reimbursable rate is calculated. | Deducted from budgeted cost before reimbursable rate is calculated. Gross earnings deducted and no allowance made for bad debts. | Deducted from budgeted cost before reimbursable inpatient rate is calculated. Gross earnings deducted and no allowance made for bad debts. |

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| Differential charges | The Ministry of Social Affairs retains all, except a certain percentage known as "incentive" which goes towards administration costs. | Base hospital retains 20 percent of net differential earnings. Regional hospital retains 15 percent of net differential earnings. District hospital retains 10 percent of net differential earnings. | Hospitals retain 50 percent of room differential. | Hospital not permitted to retain room differential. | Hospitals retain 50 percent of room differential. |
| Indigent payments | All eligible residents of the Province are entitled to hospital insurance benefits. | All qualified residents are covered under the plan. | Not applicable | All indigents covered under plan if qualified residents. | Since this is a nonpremium province a person's financial status would have no bearing on coverage. |
| Controls | Admission-discharge forms, long stay (30 days) reports are required for each hospitalization. Operating costs of the hospital are controlled by the yearly approved budget. Monthly statistical and quarterly financial statements are required from public hospitals. Budget forms are verified by a representative of the Department of Social Affairs. There is also an admission-discharge form for outpatient services. | Admission sheet and long stay (30 days) form required on each patient to substantiate that hopsitalization is medically necessary. Budgets are approved by the Department of Health. Monthly and annual operating statements are submitted to the Department and officers of Health. Advisory Committee on Hospital Standards reviews the operations of hospitals and acts as a certification credentials committee on request. | Admission sheet and long stay (30 days) form required on each patient to substantiate that hospitalization is medically necessary. Budget must be approved by rate board. Control program organized at 2 levels: Regional: Standards Committee (representatives from each hospital in region). Establishes standard of care and proper utilization of service in region. Province: Hospital counselors of the Commission. | Admission sheet and long stay (15 days) form required on each patient to substantiate that hospitalization is medically necessary. Budgets are reviewed by a rate board before submission to the Commission. The Commission has medical, hospital, and nursing advisory committees, and has a division of Hospital Standards and Administration. Counselling services are provided to the Hospital on request. | Admission sheet and long stay (30 days) form required on each patient to substantiate that hospitalization is medically necessary. Budgets are approved by the Department of Health. Quarterly and annual operating statements are submitted to the Department and officers of Health. |

| | Northwest Territories | Yukon Territory |
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| Capital financing | If construction approved by the hospital insurance plan. Territorial government matches the Federal grants and may make substantially higher grants. Approved equipment financed through hospital insurance on "outright purchase" basis. | If construction approved by the hospital insurance plan. Territorial Government matches the Federal grants and may make substantially higher grants. Approved equipment financed through hospital insurance on "outright purchase" basis. |
| Administration | Hospital Insurance Services Board of 3 members, appointed by the Commissioner of the Northwest Territories, for purposes of administering the ordinance and regulations; consultant services provided by Hospital Services Planning Division. | Provincial authority is Commissioner of the Yukon Territory, with an appointed Administrator responsible for administering the plan. |
| Benefits | Inpatients: Standard ward, all approved and available services. Outpatients: (i) Emergency and followup treatment of injuries; (ii) Medically necessary diagnostic radiological examinations with necessary interpretations; (iii) Laboratory examinations; (iv) Minor surgical procedures. | Inpatients: Standard ward, all approved and available services. Outpatients: Diagnosis and treatment of an injury, illness or disability with certain limited exceptions (include X-ray, laboratory and drugs). |
| Method of hospital payments. | 12 monthly payments based on approved budget. | 12 monthly payments based on approved budget, and per diem payments. Outpatients: paid monthly according to approved schedule. |
| Adjustments of hospital payments. | Final review and adjustment made at yearend when audited statements available. | Final review and adjustment made at yearend when audited statements available. |
| Depreciation on buildings and interest on capital debt. | Not allowable | Not allowable. |
| Waiting period | 3 mo | 3 mo. |
| Out-of-Province benefits. | Inpatients: Rate approved for hospital by its own provincial plan less Northwest Territories coinsurance. Outpatients: Same benefits as in Northwest Territories; Outside Canada; maximum applied as to rate. | Inpatients: Rate approved for hospital by its own Provincial plan. Outpatients: Same benefits as in Territory. Outside Canada: maximum applied as to rate. |
| Method of Provincial financing. | Consolidated revenue | Consolidated revenue. |
| Authorized charges | Inpatients: $1.50 coinsurance per day for adults and children and newborns. | None. |
| Outpatient revenue | Deducted from budgeted cost before reimbursable rate is calculated. | Deducted from budgeted cost before reimbursable rate is calculated. |
| Differential charges | Not applicable | Not applicable. |
| Indigent payments | All indigents covered under plan if qualified residents. | All indigents covered under plan if qualified residents. |
| Controls | Admission sheet and long stay (30 days) form required on each patient to substantiate that hospitalization is medically necessary. Reports identifying beneficiaries and services provided for outpatient care. Budgets, monthly operating reports and auditors' annual financial statements submitted to plan. | Admission sheet and long stay (30 days) form required on each patient to substantiate that hospitalization is medically necessary. Reports identifying beneficiaries and services provided for outpatient care. Budgets, monthly operating reports and auditors' annual financial statements submitted to plan. |

# Appendix II

*Comparison of Provincial medical/health services plans*

| | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario |
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| Name of plan | Medical services plan of British Columbia. | Alberta health care insurance plan. | Saskatchewan medical care insurance plan. | Manitoba health services insurance plan. | Ontario health insurance plan (OHIP). |
| Provincial legislation | Medical Grant Act and regulations; Medical Services Act and regulations. | The Alberta Health Care Insurance Act and regulations; The Health Insurance Premiums Act and regulations. | The Saskatchewan Medical Care Insurance Act and regulations. The Medical Care Insurance Supplementary Provisions Act. 1968. | The Health Services Insurance Act and regulations. | The Health Insurance Act, 1972 and regulations. |
| Effective date | July 1, 1968 | July 1, 1969. Effective July 1, 1970 the plan was amended to include hospital benefits in addition to medical and related services, and to offer, as an option, Alberta Blue Cross membership at reduced rates on a nongroup basis to residents not in arrears for their basic premium. | July 1, 1962 | The act, proclaimed on Oct. 21, 1970, provides for the continuation and amalgamation of Manitoba health plan which came into effect on Apr. 1, 1969, and The Manitoba hospital services plan. | Medical services plan introduced on Oct. 1, 1969. Effective Apr. 1, 1972, the Province's medical services and hospital plans were amalgamated into 1 plan. |
| Administration and method of operation. | Administered by the Medical Care Commission of British Columbia through 3 licensed carriers which are nonprofit and act only as agents of the Commission to enroll residents, collect premiums and pay accounts. Licensed carriers do not assess or approve accounts or determine amounts to be paid for insured services. | Administered and operated by The Alberta Health Care Insurance Commission. | Administered by the Saskatchewan Medical Care Insurance Commission. Approved nonprofit health agencies may provide services of receiving statements of accounts from medical members for insured services, receiving payments from the Commission and making payments to medical members. | The Manitoba Health Services Commission, a 9 man Commission reporting to the Minister of Health and Social Development, administers both the medical and hospital insurance programs in Manitoba. An executive director is the chief executive officer responsible for the day-to-day administration of the plan. | The Minister of Health is responsible in respect of the administration and operation of the plan. A general manager administers and is chief executive officer of the plan. |

| | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario |
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| Method of provincial financing. | Monthly premiums: Single $5, family of 2 $10, family of 3 or more $12.50. Subsidies available which reduce monthly premiums to $.050, $1 and $1.25 for residents with no taxable income, and to $2.50, $5 and $6.25 for residents whose taxable income does not exceed $1,000. | Annual combined premium for basic health services and insured hospital services; $69 single; $138 family of 2 or more. No resident age 65 or over is liable for payment of premiums for himself or any of his dependents. Subsidized premium rates are available when taxable income is no more than $500 in the case of a single person and $1,000 for a family. Social assistance recipients have full premium paid. | Effective Jan. 1, 1974 no premiums will be levied. The plan is financed by general revenues of the Province and Federal contributions. | General revenues of the Province. | The combined premium for all insured health services is $11 per month for a single person and $22 per month for couples and families. Premium is waived for all residents 65 years of age and over (and for their eligible dependants under age 65) and for all with no taxable income after 12 mo. residency in Ontario. Persons in receipt of social assistance are covered without application and without payment of a premium. Single persons having taxable income of not more than $1,000, and persons with dependants with a total taxable income of not more than $2,000 are entitled to premium assistance amounting to ½ the regular premiums. Temporary assistance may be granted during unemployment, illness, disability or financial hardship. |
| Utilization fees | None | A hospital admission charge of $5. This fee is noninsurable. | None | None | Copayment of $4 per day for extended care services in an approved licensed nursing home. |

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| Insured persons | It is the responsibility of every resident to become enrolled in and maintain coverage under the plan for himself and his dependants either personally or through arrangement with his employer or a person acting on his behalf. | Every resident must register himself and his dependants. Residents who object in principle to the plan may elect to opt-out. Each election is effective only for the 12 mo period starting on July 1 following the date the election is signed. A new resident from outside Canada must register no later than 1 mo after date of arrival. If a new resident previously resided elsewhere in Canada, he must register before the end of the 2d month following the month in which he arrives in Alberta (there is additional provision for traveling time). | All residents must be registered to be eligible for coverage. | Every resident of Manitoba is required to register himself and his dependants. A registration certificate is issued to each single person or family head. | Every person who is a resident of Ontario is entitled to become an insured person upon application and every dependant of an insured person is an insured person. Coverage is mandatory for employees of an employer if their number totals 15 or more. Employee groups of more than 5 but less than 15 persons may on application form a mandatory group; organizations having 15 or more members may apply to and be designated by the general manager as a collector's group. |
| Date registration becomes effective. | A resident is eligible for coverage after a waiting period ending at midnight on the last day of the 2d month following the month in which he becomes a resident. If application is made during the waiting period or within 1 mo of becoming eligible, coverage is effective on the 1st day of the 3d month following the month of arrival; otherwise, on the 1st day of the 2d calendar month following the month in which application is received by the carrier. | On the 1st day of the 3d month after date of application for registration. If occurring within the period prescribed for new residents from outside Canada, on date of arrival; if from elsewhere in Canada, on 1st day of 3d month following arrival (with provision for traveling time). If later, on 1st day of 3d month after date of application. | Newcomers to Saskatchewan from other parts of Canada are required to register for coverage and are provided with coverage from the 1st day of the 3d month following the date they establish residence in the Province. Landed immigrants and returning Canadians who establish residence in Saskatchewan on or before the 1st day of the 3d month following their arrival in Canada are provided coverage from the date they establish residence and must register for coverage. | If previously resident in another province or territory, benefits are available on the 1st day of the 3d month after arrival. If previously resident outside Canada, benefits are available on the date of arrival. | On the 1st day of the 3d month after making application and paying the 1st premium. For a person taking up residence in Ontario having come from another Canadian Province where he was insured under a government health plan, coverage commences on the 1st day of the 3d month next following that in which he took up residence provided application is made and the premium paid within 3 months after taking up residency in Ontario. Landed immigrants and foreign students are covered on the 1st of the month following application if 1st premium paid within 3 months after arrival in the Province. |

| | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario |
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| Insured Services | Services rendered by a medical practitioner that are medically required; diagnostic X-ray and laboratory services; anaesthetic services; physiotherapy treatments up to a limit of $50 per patient and a maximum of $100 per family in any 1 yr, where performed other than in general or rehabilitative hospitals. Treatments must be rendered in British Columbia by registered practitioner on instructions of, or referral by, a medical practitioner; special nursing services of a registered nurse when rendered in British Columbia but to a maximum of $40 per patient in any 1 yr where services are deemed advisable by a medical practitioner; services of a member of the Victorian Order of Nurses acting under or with an attending medical practitioner when rendered in British Columbia. Plan pays at rate of $2 net per visit to a maximum of $40 per patient per year. Limit does not apply to administering of injections on instructions of a physician; services rendered at certain outposts in British Columbia where services of a medical practitioner not regularly available, by Red Cross Society nurses. Payment is at rate of | Basic health services: These include the "insured services" under the Federal Act which are eligible for Federal-Provincial cost sharing plus some additional services for which the Province assumes full financial responsibility. (see 1–5): 1) insured services: all services rendered by physicians and osteopaths that are medically required; 2) services of dental surgeons in the field of oral surgery that are (a) specified in regulations (b) specified in regulations but are not "insured services"; 3) optometric services limited to refractions for the fitting of eye glasses once a year. Benefit payable shall not exceed $12.50 for each; 4) chiropractic services: benefits payable are actual charges not over $6 a visit and not over $10 for 1 X-ray, and subject to a total of $100 per benefit period for single residents and $150 per benefit period for residents with 1 or more dependents: 5) services rendered and appliances provided by a podiatrist: benefits payable as per the Alberta Pediatry Association schedule of fees approved by the Commission. Benefits limited to $100 per benefit period for single resident and $150 per benefit period | Medical services: diagnosis and treatment of all medical disabilities and conditions. Surgical services: surgical procedures including diagnosis, pre- and post-operative care. Maternity services and new-born care. Anaesthesia. X-ray procedures provided outside a hospital by specialists in radiology. Laboratory services (laboratory and X-ray procedures in hospital are covered under the hospital plan). Preventive medical services: inoculations and vaccinations, routine physical examinations. Dental services: where provided by a dentist in conjunction with maxillo-facial surgery when required to treat a condition caused by an accident; for orthodontic care of cleft palate, and in connection with abnormalities of the mouth. Chiropractic services: visit services and X-ray services. Refraction provided by a physician or an optometrist but limited to 1 per year where beneficiary has not reached 17th birthday; 1 every 3 years for persons aged 17 to 46 years, and 1 every 2 years for persons beyond age 46. | Medical services: All personal health care services (except those listed under exclusions) that are medically required and provided by a medical practitioner, including visits to the doctor's office, house calls and doctor's services in hospital. Dental services: Certain dental services when performed in hospital by a dentist. Optometric services: A complete eye examination including refraction and prescription once a year and any subsequent examinations which are required for medical reasons. Chiropractic services: Palpating and adjusting by hand of the articulations of the spinal column and other articulations. The amount payable in a 12 mo period commencing July 1st is: (i) up to $50 for a single person; (ii) up to $100 for a family of 3 or less; (iii) up to $150 for a family of 4 or more. Prosthetic and orthotic devices: When prescribed by a medical practitioner, insured services include: (i) limb prosthetic devices and services; (ii) with prior approval of the Commission, limb and spinal orthotic devices and services; (iii) artificial eyes. | Physicians services: Medically necessary services rendered by a physician. Hospital services: 1) Accommodation and meals at the standard or public ward level. 2) Hospital services on an inpatient and outpatient basis when medically necessary in the diagnosis and treatment of illness or injury. 3) Occupational therapy and physiotherapy in approved Canadian hospitals when prescribed by a physician as a medically necessary course of treatment. Physiotherapy also is covered in Ontario in approved private nonhospital facilities. 4) Speech therapy for the treatment of organic illness or injury. Nursing home services and home-care: 1) Where an insured person, who has resided in Ontario for 1 yr or longer, requires continuing nursing service and regular medical supervision in a participating nursing home or home for the aged, the plan will provide benefits toward the approved standard ward costs of such care. Eligible patients are required to pay $4 per day plus any additional charges by the home for preferred accommodation. (The plan refers to this benefit as "extended health care".) 2) |

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| $2 per office service, $4 per house visit where services rendered under instructions of a medical practitioner or consist of treatment for minor injuries and infection; orthoptic treatments when rendered in British Columbia on instructions of or referral by, a medical practitioner but up to a limit of $50 per patient in any 1 yr and a maximum of $100 per family; services of chiropractors and naturopathic physicians up to a limit with each type of practitioner of $50 per patient and a maximum of $100 per family in any 1 yr but no payment for X-rays taken by the practitioners nor for services performed outside British Columbia, services of podiatrists rendered in British Columbia but not to exceed $50 per patient in any one year and a maximum of $100 per family for services rendered otherwise than on instructions of, or referral by, a medical practioner; no payment for X-rays; services performed in British Columbia of optometrists for diagnostic optometric services and provision of prescription if lenses are required; medically required surgical procedures commonly performed only by a surgeon or a dental surgeon when performed in a British Columbia hospital by | for residents with 1 or more dependents. Extended health benefits: provides benefits to a resident 65 years of age and over and his spouse and dependents with respect to eyeglasses, restorative, surgical and prosthetic dental care, hearing aids, and surgical and medical supplies, appliances and equipment. Hospital services: Insured hospital services which are provided under the Alberta Hospitalization benefits plan. Optional health services: Residents, provided they are not in arrears for their basic premium, may obtain from the Commission Alberta Blue Cross coverage at reduced rates on an individual nongroup basis. Single rate is $24 per benefit period if taxable income over $500 in preceding tax year; $18 if less than $500. Family rate, $48 if income over $1,000; $36 if less than $1,000. Optional health services are: 1) hospital benefits: differential charges for semiprivate and private ward accommodation; allowance of up to $360 per benefit period toward cost of preferred accommodation in an auxiliary hospital in Canada: allowance of up to $40 per day to apply against hospital charges remaining after government plan benefit applied where participant admitted to a public general | Home care in respect of necessary health care services prescribed by a physician when the services are provided in the patient's home through an organized home care program in Ontario. Dental care in hospital: Specified dental surgical procedures performed in an approved hospital by a dental surgeon who is a member of the hospital's dental staff. (Benefits not provided for surgical removal of fewer than 8 teeth unless there are medical complications.) Other practitioner services: 1) Optometrists—eye examinations by refraction to determine the need for glasses. Benefit payment is $10 per person. 2) Chiropractors—services rendered in an office, institution or home to a maximum of $100 per person plus up to $25 for related X-ray examinations in a 12-mo period beginning July 1 each year. 3) Osteopaths—services rendered in an office, institution or home to a maximum of $100 per person plus up to $25 for related X-ray examinations in a 12-mo period beginning July 1 each year. 4) Chiropodists (podiatrists)—services rendered in an office, institution or home to a maximum of $100 per person plus up to $25 for related X-ray examinations in a 12-mo period be- |

| | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario |
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| Insured Services—Con. | dental surgeons where the insured person is admitted as an inpatient or as a patient under the day care surgery program. | active treatment hospital outside Alberta, and payment of hospital outpatient charges remaining after government plan benefit applied where expense incurred outside Alberta; 2) other services benefits: accumulated eligible expense under single or family coverage in excess of $15 per benefit period is reimbursed within the limits noted below: Ambulance service—up to $100 per covered person per benefit period. Within town or city limits benefits limited to $15 a trip, $30 for a period of disability. Appliances—artificial eyes, artificial limbs, braces where provided or repaired on written order of a physician. Benefit is actual charges for prothesis or repair. Dental care—benefits are actual charges for repair or extraction of natural teeth damaged through accidental injury. Drugs—drugs and medication (including insulin) obtained on the prescription of a physician and supplied by a licensed pharmacist. Benefit payable is 80 percent of actual charges. Home nursing—charges | | | ginning July 1 each year. Ambulance services: If use of an ambulance supplied by a licensed ambulance service as medically necessary, an insured resident is required to pay only $5 for a land ambulance trip of 25 miles or less, plus 15 cents for each mile over 25 miles, but not more than $25 in all for 1 trip, and $25 for an authorized air ambulance trip (including the cost of connecting land ambulance). |

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| | | made by a practical or registered nurse for home care ordered by physician. Benefit not to exceed $100 per benefit period under single or family coverage. Clinical psychologist—treatment of emotional or mental illness. Reimbursement of $20 for 1st hour and $5 for each subsequent half-hour with a maximum of $100 in a benefit period under single or family coverage. Naturopathic services—provided by a naturopath for a disability. Benefits are actual charges not exceeding $4 a visit with a maximum of $100 in a benefit period under single or family, coverage. | | | |
| Exclusions | Services a person is eligible for and entitled to under various provincial and Federal Acts such as Workmen's Compensation Act, Hospital Insurance Act, Veterans' Rehabilitation Act, etc.; medicolegal services; pathology, radiology, and (or) electrodiagnostic services performed in British Columbia at a laboratory that is not an approved laboratory; services for industrial or insurance purposes; advice by telephone; travelling; cosmetic service to a person over age 15; services which, on review of medical, the Commission deter- | Under basic health services: services that a person is eligible for and entitled to under various Provincial and Federal Acts, such as the Workmen's Compensation Act etc.; examinations required for the use of 3rd parties; services not medically required; laboratory and X-ray procedures performed in facilities not approved by the Commission; eye glasses, wigs, hearing aids or dentures; advice by telephone; ambulance or other transportation services. Under hospital services: nursing home benefits. | Services received under various Provincial and Federal Acts, such as Workmen's Compensation Act, etc.; travelling by a physician; ambulance services and other forms of transportation of patients; services of special duty nurses; services for diagnosis or treatment of cancer; plastic or other surgery for cosmetic purposes; drugs and appliances; advice by telephone; examinations required for information of a 3rd party other than for adoptions; services provided by chiropodists, podiatrists, naturopaths or osteopaths. | Care and treatment covered by the Workmen's Compensation Board, the Department of Veterans Affairs or by statute. Services including examinations and reports at the request of a third party. Group immunization or other group services except as authorized by the Commission. Services by a medical practitioner to himself or his dependents. Fitting and supply of eyeglasses. Immunization and examinations for travel, employment and emigration. Mileage, travelling time, advice by telephone, or testimony in court. Elective | Services that a person is eligible for or entitled to under the Workmen's Compensation Act or other legislation; outpatient visits solely for the administration of drugs; cosmetic surgery unless medically required; expenses for travelling time or mileage; advice by telephone; court testimony, preparation of records, reports, certificates or communications; any service or examination for insurance purposes, school admission, college, university, camp or association, employment, passport, visa or other similar document, legal requirements or pro- |

| | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario |
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| Exclusions—Continued | mines are not medically required. | | | plastic surgery for cosmetic purposes except where the Commission is satisfied on submission of medical evidence that surgery is required. Services provided by psychologists, chiropodists, naturopaths, podiatrists and other practitioners not provided for in legislation. | ceedings; laboratory services and clinical pathology, except when ordered by a physician and performed under the direction of a physician; dental care for dental purposes, including X-ray and anesthetist services other than the dental procedures specified in regulations; special appliances; services that the general manager determines upon review are not insured services because they were not medically required by the patient. |
| Out-of-Province benefits | Payment for costs of insured services up to an amount not exceeding the amount payable in British Columbia for the same service. | A resident continues to be entitled to insured services during temporary absence from Alberta. As applied to residents absent with the intention of returning to Alberta "temporarily absent" means during attendance at an accredited institution, college or university; a vacation, visit, business engagement or employment where the absence is not more than 12 mo, and education leave from employment to take advanced or supplementary training or sabbatical leave where the absence is not more than 24 mo. Benefits for services received outside Alberta are paid at the rates payable in Alberta. | While a resident is temporarily absent for up to 12 mo coverage continues for all insured services if they are provided by authorized persons. Payment normally is limited to the amount payable in Saskatchewan. | Payment for benefits is in accordance with the Manitoba fee schedule. | Full rate in other Canadian Provinces less any coinsurance or capital charges made by province concerned. 75 percent of standard ward for elective admissions in the United States including room, board and all insured extras. 100 percent of accidents anywhere in the world. 100 percent of standard ward care in all other cases occurring outside Canada or the United States. |

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| Extension of coverage after loss of residence. | Coverage ceases at midnight of the last day of the 2nd month following the month in which a person leaves the Province. if the person leaves British Columbia but continues to live in Canada a period of travelling time not exceeding 3 mo may be added to the period of extended coverate. Students in full time attendance at recognized institutions outside the Province may continue to be insured persons under the plan. The head of a family whose dependants continue to reside in the Province and are maintained by him may continue under coverage during absence from the province for 12 mo. | Coverage is extended in accordance with a certificate of continuing coverage issued on application by the Commission. The certificate entitles a resident leaving to establish residence anywhere outside Alberta to continuing coverage up to 3 mo from the date of departure and, when travelling time required, for a further period not exceeding 1 mo. | Up to the 1st day of the 3rd calendar month following the date new residence is established. | (i) Persons leaving Manitoba permanently may apply for an out-of-Province certificate and receive benefits to the last day of the 2d month following arrival in new place of residence. (ii) Temporary absence for up to 12 mo permitted without loss of coverage. | If an unsured person becomes a resident of another Province: until his coverage under the plan in that Province takes effect or after 4 mo which ever occurs 1st. Otherwise, for the period for which the insured person has paid the premiums in advance but not to exceed 3 mo. |
| Method and scale of payments to physicians. | A medical practitioner may elect to collect fees otherwise than from the plan without loss of benefit to the insured. Participating physicians submit claims to and receive payment from Commission through a licensed carrier. Payment based on tariff of fees agreed upon upon between Commission and the British Columbia Medical Association. Nonparticipating physicians must complete claim form for or furnish information to an insured person so that he may claim his benefit under the plan. | A practitioner may send accounts to the Commission on the form prescribed and receive payment. A beneficiary may submit the itemized receipt or the account of the practitioner to the Commission and receive payment. Practitioners sending accounts to beneficiaries must furnish information so that the beneficiaries are enabled to submit claims to the Commission. Rates of benefits paid for physicians' services are prescribed in Commission by-laws. Currently payments are in accordance with by-law No. 5/72, effective Nov. 1, 1972. | Physicians may enter into agreement with Commission with respect to payment or may remain outside the plan. Participating physicians submit claims to and receive payment from Commission. Payment for insured services is made on the basis of 100 percent of the Commission's own payment schedule, published on Aug. 1, 1972, and in accordance with the Commission's assessment rules. Nonparticipating physicians must furnish information to patient so as to permit payment to be made by the Commission to beneficiary. | Doctors may elect to receive payment for services directly from the Commission or collect their fees from their patients. Nonparticipating doctors must give reasonable notice to patients that payment will be collected directly. Participating physicians are paid directly by the Commission and are not allowed to extra bill patients. Payment of services made in accordance with Manitoba schedule of benefits. | Physicians may submit all claims to and receive payment from the plan as payment in full of the account, or they may bill their patients for all services. If the latter, they must give prior advice to the patient of any charges over the fee schedule. Patients are then responsible for any difference. Other health practitioners may or may not bill the plan directly. In either case the patient is responsible for the difference between the amount allowed by the plan and the amount charged by the practitioners. |

| | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario |
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| Provision for extra billing by physicians. | Participating physicians: only if reasonable notice given to insured persons, insureds consent in writing and the amounts of extra billing are made known to the Commission. Nonparticipating physicians: Although they deal directly with patients for payment insured persons are entitled to reimbursement under the plan at plan benefit levels and extra billing is allowed only if physicians give notice in writing, there is written agreement between physicians and insureds on the amount of extra billing. The insured persons submit claims to the Commission. If any insured person agrees to pay an amount in excess of the fee prescribed by the Commission, neither the Commission nor the carrier shall be liable for the excess. | Physicians and other practitioners have right to make agreement or arrangement with any person re: remuneration to be paid to them if the agreement or arrangement is made before services are rendered. | Participating physicians: accept payment from Commission as payment in full for service. Nonparticipating physicians: may deal directly with patient in respect of payment in which event patient may receive from the Commission only the amount to which he is entitled under the plan. | See "Method and Scale of Payments to Physicians." | Only where the physician has elected not to submit accounts directly to the plan. |

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| Name of plan | The Quebec health insurance plan. | Medicare New Brunswick. | Nova Scotia medical services insurance plan. | Health services payment plan. | Newfoundland medical care plan. |
| Provincial legislation | The Health Insurance Act and regulations; the Health Insurance Board Act. | Medicial Services Payment Act and regulations. | Medicial Care Insurance Act and regulations. | The Health Services Payment Act and regulations. | The Newfoundland Medical Care Insurance Act, 1968; The Newfoundland Medical Care Insurance (Insured Services) regulations, 1973; The Newfoundland Medical Care Insurance (beneficiaries and enquiries) regulations, 1973; The Newfoundland Medical Services Insurance (physicians and fees) regulations, 1973. |
| Effective date | Nov. 1, 1970 | Jan. 1, 1971 | Apr. 1, 1969 | Dec. 1, 1970 | Apr. 1, 1969. |
| Administration and method of operation. | Administered and operated by the Quebec Health Insurance Board. | Administered and operated by the Medicare Division, Department of Health and Welfare. | The hospital and medical plans were amalgamated as of Sept. 1, 1973 under a Health Services and Insurance Commission. The M.S.I. plan is administered and operated by Maritime Medical Care Incorporated on a nonprofit basis by an authority consisting of the Commission and and the corporation. | Administered and operated by The Health Services Commission of Prince Edward Island. | Administered and operated by the Newfoundland Medical Care Commission. |
| Method of Provincial financing. | Contributions to the plan are levied by the Department of Revenue as follows: Employers—0.8 percent of payroll. Individuals—married persons whose total net income for the year is over $4,000 and single persons whose total net income is over $2,000 must pay an annual contribution equal to 0.8 percent of their net income up to a maximum amount of $125 when salary constitutes three-fourths or more of their net income and up to a | General revenues of the Province and Federal contributions. No premiums charged. | General revenues of the Province and Federal contributions. No premiums charged. | General revenues of the Province and Federal contributions. No premiums charged. | General revenues of the Province and Federal contributions. No premiums charged. |

| | Quebec | New Brunswick | Nova Scotia | Prince Edward Island | Newfoundland |
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| Method of Provincial financing—Continued | maximum of $200 in all other cases. Persons whose net incomes are less than the $4,000 and $2,000 referred to make no contribution but are entitled to all benefits of the plan. | | | | |
| Utilization fees | None | None | None | None | None. |
| Insured persons | Each resident who is not a dependant must register himself and his dependants with the Board. The plan covers all persons who comply with the definition of residents. | All residents who are registered. Regulations provide that "A beneficiary may register" and to that extent the plan is optional rather than compulsory. | All residents who are registered. | All residents required to register themselves and dependants and have a social insurance number. | Every resident is a beneficiary and entitled to insured services. |
| Date registration becomes effective. | Persons who settle in Quebec after leaving another Canadian Province are entitled to benefit from the Quebec plan as soon as such other province's plan ceases to apply to them. Otherwise, a person is entitled to benefit on becoming a resident. | 1st day of the 3d month following the month of arrival in the Province. Landed immigrants and returning Canadian citizens: as of the date of arrival in Canada provided application is made within 30 days of establishing residence in the Province. | Persons moving to Nova Scotia from outside Canada are provided with 1st-day coverage; persons moving to Nova Scotia from another area of Canada are covered after 3 months' residency, on registration. | After residence in Province for 2 full consecutive calendar months from date on which residence established. Landed immigrants, repatriated Canadians, returning Canadians and returning landed immigrants are entitled to benefits from the date of establishing permanent residence in the Province provided they have registered. | If entering Newfoundland from another Province, will become eligible on the 1st day of the 3d month following the month of arrival. Otherwise from date of arrival. |
| Insured services | All services rendered by physicians that are medically required. Specified oral surgery rendered by a dental surgeon in a university establishment or in a hospital. Services rendered by optometrists, including eye examinations, but the complete eyesight examination, the summary eyesight examination and colour-blindness test not covered if they are rendered more than once during each 12 mo period. For persons entitled | "Entitled services" are all services rendered by medical practitioners that are medically required including a number of specified dental surgical procedures when performed in a hospital by a dental surgeon. | All necessary medical and surgical services including: anaesthetists' services; complete obstetrical care; treatment of fractures and dislocations; all necessary referred specialist services; all required diagnostic services except those available under Hospital Insurance Act; eye examinations (including refraction); well baby care and physical examinations where deemed medically required by the physician; specified surgical dental pro- | All services rendered by physicians that are medically required (basic health services) and specified oral surgery procedures when performed in a hospital by a dentist when the condition of the patient is such that the service is medically required to be rendered in hospital. | All physicians' services medically required including doctors' visits in office, hospital or home; diagnosis and treatment of illness and injuries and treatment of fractures and dislocations; care and treatment before, during and after operations; anaesthesia; complete maternity care; services of specialists on referral; specific surgical procedures rendered in hospital by dentists; diagnostic and therapeutic X-ray and laboratory services in |

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| | to social aid in accordance with various provincial and Federal acts, the Board also assumes the cost of services and medications furnished by pharmacists on the prescription of a physician or dental surgeon. | | cedures (listed in schedule "A" to regulations) when performed in a hospital by a dental surgeon. | | facilities approved by the Commission which are not provided under Government hospital insurance. |
| Exclusions | Services which a person may obtain and is entitled to under other Provincial or Federal acts; examinations or services not related to a process of cure or prevention of illness such as examinations for insurance, employment, passports, etc.; psychoanalysis in any form unless rendered in an institution authorized for the purpose by the Minister of Health; services provided for purely aesthetic purposes; consultations by telecommunication or correspondence; services rendered by a professional to his spouse or children; any report, testimony, certificate when required for purposes of justice or by a 3d party; visits made for the sole purpose of renewing a prescription; examinations, vaccinations, etc., given to a group of persons unless authorized by the Board or for school or camp purposes; adjustment of glasses or contact lenses. | Services covered by the Workmen's Compensation Board, Department of Veterans Affairs or other legislation; medicines, drugs, materials, surgical supplies or prosthetic devices; elective plastic surgery or other services for cosmetic purposes; advice or prescription renewal by telephone; examination of medical records or certificates at the request of a 3d party; dental services provided by a physician; mileage or travelling time; testimony in court or before any other tribunal; immunization, examinations or certificates for purposes of travel, employment, insurance or at the request of a 3d party; services provided by physicians to members of their immediate families; pathology and radiology services; psychoanalysis; electrocardiogram where not performed by a specialist in internal medicine; laboratory procedures not included as part of an examination or consultation fee; refractions performed by medical practitioners other than for the purpose of diagnosing diseases of the eye; immuniza- | Services available under Workmen's Compensation Act, Nova Scotia Hospital Insurance Act or other Government statute; ambulance; mileage or travelling time; telephone advice or prescriptions; examinations at the request of a 3d party; drugs; cost of preparation of records, reports and certificates by a physician; eye glasses, hearing aids, surgical appliances, crutches, artificial limbs or other prosthetic appliances; dental services (other than those listed in schedule "A"); services of optometrists, chiropractors, podiatrists, physiotherapists, nurses or other paramedical personnel; laboratory or diagnostic radiological services rendered in Nova Scotia. | Services that a person eligible for and entitled to under Federal or Provincial acts such as Workmen's Compensation, Hospital Insurance, etc.; mileage, travel or detention time unless approved by the Commission; advice or prescriptions by telephone; examinations in connection with employment, insurance, camp, etc.; group examinations, immunizations or inoculations unless approved by the Commission; testimony in a court; preparation of records, reports, certificates or communications; surgery for cosmetic purposes unless medically required; dental services other than the specified oral surgery in hospital; dressings, drugs, vaccines, biologicals, and related materials; eye glasses and special appliances; physiotherapy and similar treatments; laboratory or radiological services provided under the hospital and diagnostic Services Insurance Act; services not rendered by or under the direct supervision of a physician, and services rendered by a physician to members | Services to which a beneficiary is entitled under any Federal or Provincial act or any laws in force where services are provided; advice by telephone; cost of preparation by a physician of records, reports or certificates for or on behalf of a beneficiary; transportation charges for patient or doctor; examinations at request of a third party; glasses, hearing aids, splints and appliances; plastic or other surgery for cosmetic purposes unless medically indicated. |

| | Quebec | New Brunswick | Nova Scotia | Prince Edward Island | Newfoundland |
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| Exclusions—Continued | | tions which are available through public health clinics or which do not for medical reasons require that they be given by a medical practitioner; eye glasses, contact lens, or frames; services provided by dentists, private nurses, optometrists, pharmacists, opticians, chiropractors, podiatrists, chiropodists, naturopaths, or osteopaths. | | of his own family unless approved by the Commission. | |
| Out-of-Province benefits. | Coverage continues during temporary absence from the Province. A resident is entitled to reimbursement of the cost of insured services but the amount may not esceed the amount provided under the Quebec plan. | Coverage continues during temporary absence from the Province for the purpose of a vacation, visit or business but not where the absence exceeds 12-consecutive months. Coverage continues for a beneficiary who is temporarily absent for the express purpose of furthering his education in a Province or country where he is not eligible for coverage under a medical care plan of that Province or country but not where the absence exceeds 12 mo. | All insured services are covered during temporary absence not exceeding period of approximately 12 mo. Benefit entitlement not to exceed amount that would have been paid had the services been provided in Nova Scotia. | If basic health services required as a result of sudden illness or accident or on approval of the referral by the Commission, payment is (a) at the tariff of the Province in which services are rendered or (b) a tariff established by Commission when the services rendered outside Canada are considered by the Commission to be available in Canada.<br>If any basic health services not available in Canada are rendered outside Canada with prior approval of the Commission, payment will be at such rates as Commission may decide. Otherwise, benefits are payable at Prince Edward Island rates provided accounts are submitted within 6 mo. | During temporary absence; normally, up to 1 yr but the period may be extended following review. When insured services are received in another Province, the benefit paid is at the level of that Province's medical plan. Otherwise the payment is at a rate which, in the sole opinion of the Commission, is fair. |

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| Extension of coverage after loss of residence. | Persons leaving Quebec for another "medicare" Province: until expiry of that Province's waiting period, if any, but not for longer than 4 mo. Persons leaving to take up residence in a foreign country: coverage ceases immediately upon departure. | For a person who leaves the Province to establish residence outside Canada, coverage is extended for 3 mo after departure. For a person who has established residence elsewhere in Canada, coverage ceases on the 1st day of the 3d month following the month of arrival at his new residence. For any other beneficiary who, in the opinion of the director, leaves the Province to establish residence elsewhere in Canada, coverage ceases 12 mo after date of departure. | If person becomes resident of another participating Province, up to and including the last day of the 2d month following arrival in the new Province of residence. If move is to another country coverage terminates immediately upon leaving Canada. | For residents moving to another part of Canada: for 12 mo from date of departure or until residence established in the new Province, whichever occurs earlier. A resident moving to a destination outside of Canada is deemed to be a resident for a period not exceeding 12 mo from date of departure from the Province or until he leaves Canada, whichever occurs earlier. | If a person remains in Canada, coverage terminates on the last day of the 2d month following month of departure. Outside Canada—date of departure. |
| Method and scale of payments to physicians. | Health professionals designated by the act may elect to be either participating professionals, nonparticipating professionals or professionals withdrawn. Participating professionals submit their accounts to the Board and payment received is payment in full for the services. Nonparticipating professionals may not claim payment of fees from the Board and must serve notice in writing of their status before providing services to patients. Patients of nonparticipating professionals may neither demand nor obtain from the Board reimbursement of the cost of insured services. Professionals | Medical practitioners may elect to practice outside the provisions of the act and the regulations. A participating medical practitioner normally will submit his account to the Medicare Division and the amount paid under Medicare is payment in full of the account. He may however reserve the right to charge the person to whom he renders an entitled service and may do so provided he informs the person and furnishes the information necessary to enable the person to make a claim. A nonparticipating medical practitioner must inform his patients that he is a nonparticipating practitioner | A physician may elect to collect his fees otherwise than from the corporation. Participating physicians: submit claims to and receive payment from the corporation. Nonparticipating physicians: not entitled to charge for services to a resident unless he gives reasonable notice of his election to the resident. If requested by the resident, must complete prescribed claim form or provide sufficient information to enable resident to complete. Benefit payments in accordance with a tariff established by Commission after consultation with the Medical Society of Nova Scotia. | The act provides that payment shall be not less than 85 percent of the schedule of Fees approved by P.E.I. Medical Society. A physician may elect to collect payments otherwise than from the Commission. Participating physicians submit claims to the Commission and are not entitled to receive from the Commission a fee in excess of the tariff in relation to the service rendered. Nonparticipating physicians bill patients but must furnish necessary information to enable patients to submit claims. | A physician may elect to collect payments otherwise than from the Commission. Participating physicians: accept payment from Commission as payment in full for services rendered. Nonparticipating physicians: bill their patients and patients have the right to receive amount of benefit from Commission. Payments by the Commission are at 90 percent of the Newfoundland Medical Association schedule of fees. |

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| Method and scale of payments to physicians—Continued | withdrawn from the plan may not claim payment of fees from the Board and must notify patients in writing that they must pay the professional directly but that his fees will be in accordance with the fee schedule payable by the Board. Patients of professionals withdrawn will be reimbursed by the Board on submission of claim documents. Amounts payable are fixed by a agreement between the Minister of Health and the associations representing the various categories of health professionals. | and furnish information to enable his patients to make claims against Mediccare. Payment is based on 87 percent of the schedule of fees of the New Brunswick Medical Society as amended up to and including Feb. 1, 1972. | | | |
| Provision for extra billing by physicians. | Participating professionals and professionals withdrawn are not entitled to extra-bill. Nonparticipating professionals may do so since they must notify residents requesting their services that the residents will have to pay any fees charged. | Participating medical practitioners: may charge patients for services that are entitled services and not bill the medicare division as noted above. Nonparticipating medical practitioners: deal directly with patients for payment. They must however give notice of this before providing services and afterward furnish information so as to permit patients to claim benefits from medicare. An obstetrical specialist may with respect to obstetrical care both submit an account to medicare and charge the beneficiary an additional amount not exceeding $43.50. | A physician may charge a fee in excess of the tariff if he gives reasonable notice of intention to charge a greater amount, the insured consents in writing to the extra charge, and the amount of the extra charge is made known to the Commission. | Physicians may charge a fee in excess of the Commission tariff but not exceeding the amount stipulated in the Medical Society's schedule of fees provided reasonable notice is given the patient, the patient consents and the amount of the extra charge is made known to the Commission. | Participating physicians: not permitted to extra-bill. A specialist, however, may charge a nonreferred beneficiary the difference between the GP fee and the specialist fee provided he informs the beneficiary before furnishing the service. Nonparticipating physicians: may extra-bill provided they inform the beneficiary and provide the information required by the Commission to enable payment to be made under the act to the beneficiary. |

| | Northwest Territories | Yukon Territory |
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| Name of plan | Northwest Territories Medical Care Plan. | Yukon Health Care Insurance Plan. |
| Legislation | Northwest Territories Medical Care Ordinance and Regulations. | Yukon Health Care Insurance Plan Ordinance and Regulations. |
| Effective date | Apr. 1, 1971 | Apr. 1, 1972. |
| Administration and method of operation. | Plan administered by a Director designated by the Commissioner of the Northwest Territories. | The plan is administered by the Yukon Health Care Insurance Plan Administrator designated by the Commissioner of the Yukon Territory. |
| Method of financing | Consolidated revenues of the territories and Federal contributions. No premiums charged. | The Yukon consolidated revenue fund, Federal contributions and premiums payable at rate of $6.50 per month for a single person, $12.50 for a person with 1 dependant and $14.50 per month for a person with more than 1 dependant. Exemption from payment of 50 percent of premiums may be applied for by a single person with taxable income of not more than $500; an insured person with 1 dependant with taxable income of not more than $1,000 and an insured person with 2 or more dependants with a taxable income of not more than $1,300. The Commissioner may waive payment of premium by persons of at least 12 consecutive months residency who have no taxable income. |
| Utilization fees | None | None. |
| Insured persons | All residents entitled to benefits and required to be registered prior to receiving benefits. | Every resident other than a dependant must register himself and his dependants. |
| Date registration becomes effective. | On 1st day of the 3rd mo after becoming a resident. | After 3 mos of continuous residence in the Territory. Landed immigrants and returning Canadians entitled to all benefits upon establishing residence if they do so within 3 mos of arrival in Canada. |
| Insured services | All services rendered by medical practitioners that are medically required. Specified oral surgery rendered by a dental surgeon in hospital. | Services rendered by a medical practitioner that are medically required. Specified oral surgery procedures performed in hospital. |
| Exclusions | Services that a person is eligible for or entitled to under various Federal and provincial laws; advice or prescriptions given by telephone, cosmetic surgery unless medically required; examinations not rendered for the prevention or curing of an illness; dental services other than prescribed oral surgery; drugs, dressings, vaccines, biologicals and related materials; eyeglasses; special appliances; chiropractic, physiotherapy and similar treatments; or optometric services. | Services that a person eligible for and entitled to under various Federal and Provincial laws; advice by telephone; medical-legal services; preparation of records, reports, certificates or communications; services or examinations required for industrial or insurance purposes, for camp attendance, travel, employment or required by a 3d party; cosmetic services to a person over 15 yr of age unless medically required; detention time; laboratory and X-ray procedures in facilities not approved by the Commissioner; prescriptions, drugs, and appliances; eyeglasses. |

| | Northwest Territories | Yukon Territory |
|---|---|---|
| Out-of-Province benefits. | An insured person is entitled to benefits for services received while temporarily absent from the Territories. Period of absence may, on request, extend to 12 mo. Payment in another province is in accordance with the rates for that province's plan. Payment for services received outside of Canada may not exceed the amount payable under the plan. | An insured person is entitled to insured medical services during temporary absence up to 12 mo. Payment not to exceed amount that would otherwise be payable under the plan. |
| Extension of coverage after loss of residence. | For persons leaving to take up residence elsewhere in Canada, coverage continues during period of travel and during waiting period imposed by the new province's health plan. For persons leaving to establish residence outside of Canada, coverage ceases at time of leaving the Northwest Territories. | When leaving Territory to take up residence elsewhere in Canada, coverage continues during normal traveling time and a waiting period not exceeding 3 mo. When establishing residence outside Canada, coverage ceases 3 mo after the day of leaving Territory. |
| Method and scale of payments to physicians. | A medical practitioner may elect to collect his fees otherwise than under the plan. Participating physicians submit accounts to and receive payment through the Director. Nonparticipating physicians may send accounts either to the Director or the insured person. In either case, benefit payment is made directly to the insured person. | A medical practitioner may elect to collect his fees otherwise than from the plan. Participating physicians submit accounts to and receive payment from the plan. Nonparticipating physicians deal directly with patients but must give notice of this an obtain agreement in writing from the patient regarding payment. It this case, insured persons submit claims and are entitled on payment at the plan's prescribed level. |
| Provision for extra billing by physicians. | A participating physician is not entitled to extra-bill. A nonparticipating physician may extra-bill provided reasonable notice is given the patient. | A participating physician is not entitled to extra bill. A nonparticipating physician requires approval in writing from an insured person before he may bill in excess of prescribed amounts for his services. |

NOTE.—The Medical Care Act, effective July 1, 1968, made Federal funds available to the Provinces on the condition that the Provincial plans meet certain minimum criteria. Thus, while the Federal government now shares with the Provinces the cost of providing specified medical and other health services, the methods of administering and financing the programs in each Province and the provision of services above the minimum required to qualify the programs for Federal subsidy are left to the choice of the Provinces.

For the first time, an outline of the Provincial medical/health services plans is presented in this directory.

Specific points of detail should be ascertained by reference to the applicable Acts and Regulations.

# Chapter 2. France

In 1945, the French Government passed the Ordinances of October, providing for a unification of the voluntary social insurance funds which had previously insured a large portion of the population for both benefits during periods of illness and medical care services (the combination is referred to as "sickness insurance"). Approximately 98.5 percent of the French population is now covered for sickness insurance, the majority (70 percent) through a compulsory general system covering nonagricultural workers and salaried employees. Benefits under the program include a daily sickness cash benefit, maternity and disability cash payments, and at least 75 percent reimbursement of ordinary medical expenses (physicians' fees, hospital costs, and costs of dental care and prescription drugs) and full reimbursement of medical expenses for a costly or prolonged illness.

The costs of sickness insurance are met through employer contributions of about 12.5 percent of payroll, employee contributions of 3.5 percent of earnings, and certain earmarked taxes. Deficits are covered by general revenues and transfers from other social security funds.[1] The Ministry of Health and Social Security supervises the program at the national level, with Regional Sickness Insurance Funds and Primary (local) Sickness Insurance Funds assuming responsibilities for coordination of funds, registration of the insured, payment of cash benefits, and refunds of medical expenses.[2]

## COVERAGE

Approximately 15.2 million workers are covered for sickness insurance under the general system ("general regime") and its affiliated groups. An additional 5.2 million workers are insured under other Government programs.[3]

The general regime covers salaried persons working in industry, trade, and administration. Salaried persons attached to special sectors are covered by "special regimes." These are principally for agricultural workers, electricity and gas workers (nationalized industries), seamen, miners, workers in State industries (explosives, gun factories, military force plants), and civil servants of local authorities. While the different regimes are run independently of each other, the covered benefits are the same for all kinds of salaried workers, including agricultural workers.[4]

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[1] "Main Features of Selected National Health Care Systems," Research and Statistics Note No. 9–197. U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, May 18, 1973: 3.

[2] Jozef Van Langendonck, "The European Experience in Social Health Insurance," Social Security Bulletin, July 1973: 23.

[3] Robert W. Weise, "Social Security Abroad: Medical Care Agreement With French Doctors." Social Security Bulletin, July 1972: 32.

[4] R. F. Bridgman, "Medical Care Under Social Security in France." International Journal of Health Services, November 1971: 334.

Certain nonsalaried workers are covered by special funds. This coverage has been extended to students, newspapermen, writers, artists, and civil war victims. This category of coverage has been gradually extended to certain other nonsalaried groups—in 1961, self-employed farmers were brought into the program, and in 1966, self-employed persons in nonagricultural occupations.[5]

Private voluntary funds continue to offer coverage to persons not under the compulsory scheme and also offer benefits which supplement those provided under the Government program.

Under certain conditions, coverage is also extended to foreign workers employed in France (there are special arrangements for citizens of the Common Market Countries) and to French people working abroad and overseas (especially in the former French colonies).[6]

## BENEFITS [7]

The sickness insurance program in France generally provides cash refunds to the insured for part of the cost of medical care. The insured normally pays for services out of pocket and is then reimbursed by his local sickness fund in amounts ranging from 70 to 100 percent of the costs for services, in accordance with negotiated and approved fee schedules. Minor medical treatment is not fully reimbursed. The social insurance program does, however, have a form of catastrophic coverage in that it reimburses the full cost of prolonged or unusually expensive treatment or treatment provided in the following cases:

> When the patient belongs to certain categories, such as the retired, invalids, and veterans.
>
> When the medical or surgical procedures are over a certain cost level, which is that of the normal appendectomy (all major surgery is reimbursed at 100 percent).
>
> Provision of blood, plasma, or human milk.
>
> Provision of important prosthetics and appliances.
>
> Care of premature newborns.
>
> Especially expensive treatment (e.g., cobalt therapy, artificial kidneys) and hospital stays over 30 days.
>
> Long-term diseases (e.g., tuberculosis, cardiopathies, cancer, mental disturbances, infantile diabetes).[8]

For minor medical treatment—that is, when the catastrophic type situation does not apply—the program reimburses the following amounts:

> Expensive and essential drugs—90 percent.
>
> Physician and paramedical fees and laboratory procedures in public or private nonprofit hospitals, or in hospital outpatient departments—80 percent.
>
> Hospitalization costs up to 30 days in public or nonprofit private hospitals, or proprietary institutions under an agreement with the Government—80 percent.
>
> Physician fees for home or office consultations and visits—75 percent.
>
> Laboratory tests, drugs other than essential ones, dental care outside the hospital, eyeglasses and small appliances, cure in spas—70 percent.

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[5] "Social Security and National Health Insurance in France." Embassy of France, Press and Information Service, New York, 1971: 6.

[6] Bridgman, p. 334.

[7] Ibid., pp. 335–336.

[8] The July 1972 Social Security Bulletin (p. 32) reports that, for costs of treatment for 21 "scheduled diseases," the amount payable "can be waived and the social security system may absorb the entire cost of care."

## FINANCING

Health insurance is financed mainly by payments from employers and employees in proportion to their salaries as follows:

For salaries up to a 1975 ceiling of 2,750 francs a month, the employer pays 10.45 percent and the employee 2.5 percent of the salary.[9] For monthly salaries higher than 2,750 francs, the employer pays an additional 2 percent and the employee 1 percent, calculated on the entire remaining salary, not subject to any ceiling. The combined employer-employee contributions for the average worker total about 16 percent of his earnings; this amount, however, includes contributions not only for health care but also for cash sickness and maternity benefits and for disability and death benefits. Only about four-fifths of total expenditures are actually spent on medical care; the remainder is used for the various cash benefits. Prorating the combined employer-employee contributions according to funds expended would thus alot four-fifths of the full 16 percent to health care, or about 12.8 percent.[10]

In health plans for nonagricultural self-employed workers, the size of the contribution is determined, subject to certain arrangements, on the basis of the earned income declared to the income tax administration. As a rule, the insured are divided into categories of contributions within given income brackets.

Unlike most other European systems in which the role of Government subsidies has expanded, the French program is financed almost entirely through the employer-employee contributions noted above. Partial Government subsidies from general revenues are provided only for the care of specific groups, such as pensioners, welfare recipients, students, unemployed workers, and farmers, who have little or no earnings on which to pay taxes, or in the case of serious deficits in the social insurance funds.[11] In the past, such deficits have been made up by drawing on funds from other areas of social security income (such as those for family allowances), from a surtax on automobile insurance premiums, and from an alcohol tax.

It has been estimated that approximately 66 percent of health insurance funds are derived from employers' contributions, 28 percent from insured persons' contributions, and 6 percent from Government subsidies.[12]

## ADMINISTRATION

The health insurance program in France has decentralized administration. Autonomous, semipublic funds operate at local, regional, and national levels. These primary funds are administered by boards composed of representatives of employers and the insured. All people who reside or work in a given district must be registered with the local fund serving that district.

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[9] As of December 31, 1975, one French franc was equivalent to about 21¢ in U.S. currency.

[10] Joseph G. Simanis, "National Health Systems in Eight Countries." U.S. Department of Health, Education, and Welfare, Social Security Administration Office of Research and Statistics. DHEW Publication No. (SSA) 75–11924, January 1975: 51.

[11] Van Langendonck, p. 25.

[12] Gabriel Pallez, "Urban Problems: Social Security and the Teaching Hospital [in France]." Journal of Medical Education, Dec. 1973, pt. 2: 111.

There are 122 of these primary social insurance funds whose districts usually cover a "department," the term used for an administrative and geographic political subdivision within France, corresponding somewhat to a State in the United States. Primary funds are responsible for registering the insured and for paying out sickness, maternity, death, temporary disability, and industrial injury benefits. In addition, the funds carry out certain health and social policies on behalf of the insured within the district.

Sixteen regional social insurance funds coordinate the activities of the primary funds within their jurisdictions. In particular, they develop and coordinate industrial injury prevention measures, guarantee the uniformity of charges, and pursue health and social policies.[13]

At the national level, the responsible branch of government is the Ministry of Public Health and Social Security, which is in charge of supervising the "general regime" administered through the primary and regional funds. The "special regimes" (for seamen, miners, railroad employees, etc.) are administered, wholly or in part, by the occupations concerned. Other funds covering businessmen, artisans, self-employed farmers and members of the professions are administered in a similar manner.[14]

A feature of the French system seldom observed in other countries permits social insurance funds to participate in capital expenditures for health facilities and in governmental preventive health care programs. Prior to World War II, the funds could spend their savings on the operation or subsidization of health institutions. Following the Ordinance of October 1945, which provided for the unification of the former voluntary mutual aid societies or funds, a broad health and social policy fund was created with a national center and regional branches. This central fund is no longer derived from savings but comes from a percentage of the total budget of each main social insurance branch, the proportion being determined each year by a ministerial regulation.[15]

Social insurance organizations do not have complete freedom to create or subsidize any health or social institution. They must follow a plan determined by the Ministry of Public Health and Social Security, and endorsed by the National Planning Board. Over the last 30 years, the resources of the health and social policy funds have supported about 30 percent of the capital expenditures for hospital construction and equipment, a large share of the cost of maternal and child health, tuberculosis and mental health programs, and an important part of the development of private group practice and public health centers.

The social insurance funds were also required by the Ordinances of October 1945 to offer free health examinations to their insured groups and dependents "at certain periods of their lifetime." This provision of the law has not, however, been implemented on a broad scale, with only 20 primary funds having initiated such projects by 1969.[16]

## REIMBURSEMENT METHODS

The French system utilizes both indirect and direct payment methods for health care providers. The indirect system applies mainly to institutional care.

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[13] Bridgman, p. 338.

[14] "Social Security and National Health Insurance in France," p. 19.

[15] Bridgman, p. 338.

[16] Ibid, p. 339.

When an insured person is hospitalized, he is responsible only for payment of the deductible (if any) when discharged; the hospital submits the remainder of the bill to the patient's social insurance fund for reimbursement. Reimbursement rates are fixed at a certain percentage of a ceiling value determined by a central government decision in the case of hospital care. These rates are based primarily on the cost of operating the hospital per patient per day and are also applicable to participating proprietary hospitals and nursing homes, because their cost per patient day cannot exceed that of the nearest public hospital.

In 1974, there were about 240,000 beds in public hospitals and 123,000 beds in private hospitals. About half of the private beds were in voluntary nonprofit institutions and the remainder in private, for-profit hospitals.[17] The overall bed per population ratio was about 7 beds per 1,000 population.

Forty-five percent of surgical and maternity beds were in private, rather than public, hospitals. Private hospitals registered both a shorter average length of stay and a higher rate of surgical admissions than public institutions. In 1969 the average length of stay for all public hospitals in France was 19.1 days. For private hospitals, the average length of stay in short-term acute hospitals in 1969 was 12.0 days.[18] Private hospitals registered 31 surgical admissions per year per 1,000 per 1,000 population as against 24.2 surgical admissions in public hospitals.[19]

Approval of the central government must be obtained before a private hospital can be opened. In this way, the Government tries to prevent uncontrolled competition.

Eighty percent of private, for-profit hospitals and clinics are owned totally or partially by doctors. These private, profitmaking hospitals have been discribed as "financially prosperous, because they select 'good cases,' they have a high turnover of patients, and they collect physicians' and surgeons' fees." [20]

Physicians' services and other medical care rendered to a hospital inpatient are paid for on a fee-for-service basis according to a fee schedule. In private hospitals, these fees are passed on to the hospital physician; in public hospitals, they usually are not, since the doctor is paid either a full-time or part-time salary, depending on the hours per week spent on hospital care. In addition to salaries, the medical staff of public hospitals receive a portion of their income by sharing a part of receipts from fees. In dividing these funds, some weight is given to the rank of the individual doctor.[21]

For outpatient medical care, the triangular relationship among the patient, his physician, and his social insurance fund has remained basically unchanged. The principle of direct payment of full medical fees by the patient to the physician, with partial reimbursement to the patient by his social insurance fund, is the general pattern; but in the case of care given by hospital physicians, the patient may delegate his rights to be reimbursed to a third party and pay only the deductible to his physician.

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[17] Simanis, p. 48.

[18] Richard Johnson, "Statistics Make U.S. Hospitals Look Healthy." Modern Hospital, February 1972: 102.

[19] Bridgman, p. 341.

[20] Ibid., p. 337.

[21] Simanis, p. 54.

Until recently, reimbursement rates for medical services were fixed at a certain percentage of a ceiling value which was determined by agreement between the medical profession (medical unions) and the social insurance funds, or by agreement between the funds and individual physicians, or by Government decision in the absence of any agreement, after a hearing by an interministerial committee.

This system was less than satisfactory, however, from the point of view of both the medical profession and the Government:

> This situation has been unstable and has led to periodic denunciation of agreements because of the constant tendency of physicians to increase their fees, along with the rising cost of living, while the sickness funds tend to freeze the fees and adopt anti-inflationary measures. During the negotiations, fees have run wild and the reimbursement rates have fallen to a low percentage. Patients have been very dissatisfied, and political tension has risen. A law was recently enacted which established a national matrix for ceiling fees and guaranteed for the next 4 years a fixed percentage of reimbursement. The medical profession protested, but it is most unlikely that the doctors will go on strike. At this time one should recall the high value the population has set on social insurance. On several occasions groups of workers, such as miners, were covered by special funds which gave them better protection than the general system. It happened that some mines, being exhausted, were closed by Government decision and the miners were resettled in industry. But, falling under the general social security regime, they lost some of their privileges. This was a very serious affair, despite the fact that their salaries were increased. These people preferred receiving less money in cash, but being better protected against social and sickness hazards.[22]

On November 1, 1971, a new agreement between the Government and the medical profession became effective for a period lasting until May 1, 1975. Unlike previous agreements which were applicable for only a single year and binding only within the limits of a specific geographic area, the new agreement was applicable nationwide to all practitioners except those doctors who individually elected to be excluded. Under the terms of the new agreement, participating doctors were authorized to charge the prevailing rates shown below:

| | Prevailing rates (francs) | |
|---|---|---|
| Types of care | Doctors adhering to agreement | Doctors not adhering to agreement |
| Office consultation: | | |
| General practitioner | 20 | 4. 00 |
| Specialists | 32 | 8. 00 |
| Home visits: | | |
| General practitioner | 27 | 5. 20 |
| Specialists | 40 | 10. 40 |

Seventy-five percent of the official fee schedule amounts are reimbursable by social insurance funds, the remaining 25 percent by the patient. Charges exceeding the schedule are not to be reimbursed. Fees above the standard amounts may, however, be charged by specialists or other outstanding doctors who are so designated by the regional (departmental) medical association.

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[22] Bridgman, p. 336.

Doctors who choose not to participate must inform the social insurance funds of their decision. As of March 1972, approximately 49,000 or 95.7 percent of all registered physicians were reported to be participating under the new agreement, an increase over the number of participating physicians (88 percent) in the previous year.

Patients who use nonparticipating physicians are reimbursed for home and office visits only at the maximum rates established in the fee schedule. Special medical care and retirement benefits, now available to the medical profession, are not provided to nonparticipating doctors. In addition, nonparticipating physicians are not allowed to benefit from the improved income tax provisions which permit affiliated doctors to make substantial deductions for professional expenses.[23] These provisions, when taken together would seem to explain the very high participation rate.

The 1971 agreement also introduced the concept of self-discipline by the medical profession with regard to the cost of medical care. Medical profiles showing the average cost of medical care are now published quarterly by the medical agencies. These profiles are compared with the charges made by each doctor. A medico-social commission within each department, or region, composed equally of representatives of the social insurance funds and the regional medical association is responsible for reviewing the cost profiles of any doctor whose charges substantially exceed those of his colleagues. Doctors with unjustifiable excess charges are asked to refund the amount of overcharge. Continuing abuses are considered grounds for exclusion from the program, upon the recommendation of the regional commission. It is expected that this monitoring of doctors' fees will result in an annual savings of 1 billion francs.[24]

In 1973, there were approximately 77,000 qualified doctors in France, with about 55,000 in private practice and the rest occupied in industrial pursuits, social security, hospital services, and miscellaneous activities. Less than half of those in private practice were general practitioners. About 40 percent of the private practitioners, most of them specialists, also work part-time in hospitals, clinics, or dispensaries. About 43 percent of French physicians are designated as specialists on a registry under the control of the local doctors' associations. The growth in specialty practice in recent years is explained in large part by the fact that specialists are allowed to charge usually twice the fee allotted to the general practitioner for the same service and that general practitioners normally cannot follow their patients into the hospital—even for routine X-rays or for laboratory services, the general practitioner must refer his patient to a specialist.[25]

## RISING COSTS

Escalating health costs have placed a considerable burden on the social insurance programs in France, particularly because they are designed in principle to be self-supporting. Deficits in the health insurance funds reached an estimated 1.9 billion francs in 1970. Between 1966 and 1970, the projected 7.3 percent annual rate of growth in health insurance benefits was exceeded and reached an actual rate of 8.9 percent.[26]

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[23] Weise, p. 34.

[24] Ibid.

[25] Simanis, pp. 47–48.

[26] Palmer D. Hoskins, "Recent Social Security Reforms in France." Social Security Bulletin, January 1971; p. 35.

For the period from 1960 to 1969, the total cost for the delivery of health services increased from 11.9 billion francs to 39.1 billion francs, or at an average annual rate of 14.5 percent. After taking into account factors such as population increases and inflation, medical costs still doubled during this period. Expressed in terms of the gross national product, health care expenditures rose from 4 percent in 1960 to 6.25 percent in 1969.[27]

In order to cover deficits in the health insurance funds, the Government has had to provide general revenue subsidies and also transfer a portion of the family allowance contribution rate (a separate social insurance program) to the health insurance fund. Since 1970, other economy measures have included the lowering of the fixed prices of several hundred most-often prescribed medications and the elimination from the list of reimbursable prescriptions of more than 2,000 other medications no longer considered important for modern therapy. Fixed prices of pharmaceuticals are revised at 2-year intervals on the basis of real production costs and volume of sales. Other steps taken by the Government in an attempt to contain costs have included the introduction of the multiyear fixed fee schedule and medical "cost profiles" on physicians, as described earlier.

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[27] Weise, p. 23.

# Chapter 3. Japan

With the passage of a 1922 act dealing with workers' health insurance, Japan became the first Asian country to introduce a social insurance law. The entire Japanese population is now covered by either a government-administered or a government-supervised health insurance program. There are two main programs: (1) the national health insurance program (NHI), which covers residents not insured through their employment, and (2) the employees' health insurance program (EHI), compulsory for persons employed in manufacturing, mining, and retail establishments employing five or more persons, and voluntary for workers in businesses with fewer than five employees. In addition to these two programs, there are separate, government-administered health insurance plans for seamen and day laborers. Government employees, workers in public corporations, and teachers are covered under yet another scheme, administered through mutual aid associations.

In principle, all of the health insurance programs cover the same range of benefits, including physicians' services, hospitalization, nursing, transportation, drugs, dental care, etc. However, there are variations among the plans with regard to duration of benefits, amount of patient cost-sharing, provision (or absence of provision) for cash sickness benefits in times of illness.

Under NHI, a special tax on insured persons covers 25 percent of the cost, with the remainder financed through the national treasury. For the EHI program and the separate programs for day laborers and civil servants, the employee and the employer each pay contributions, generally in equal amounts, based on earnings, but the contribution rates vary among the different plans, as do the income ceilings to which the rates are subject. All of the employee plans received a partial government subsidy.

The national health insurance program and the programs for seamen and day laborers are government-administered. The plan for civil servants is handled through mutual aid associations under the direction of the responsible government department. The employee health insurance program is managed either by approved health insurance societies (for firms employing 300 or more employees) or directly by the Government (for firms with fewer than 300 employees).

Private institutions play a major role in the Japanese health care system. More than half the hospital beds and 90 percent of general medical clinics are under private management. Reimbursement to these facilities is based on a government-approved fee schedule. Physicians and dentists are also paid in accordance with a government-approved fee schedule consisting of over 700 items of service.

## COVERAGE

Virtually the entire Japanese population is covered under one of the following programs:

(1) Employee health insurance (EHI) program, which is compulsory for any person employed by a firm, factory, hospital, or other working place which

regularly has five or more employees. Exceptions are persons employed in restaurants, hotels, fishing, forestry, and agriculture who may, however, elect to become insured voluntarily. For purposes of voluntary coverage, over half the employees in the business must consent, and the action must have the approval of the prefectural governor.

The EHI program is administered either directly by the national government or by a health insurance society especially established for this purpose. Under the government-managed part of the program, there were a total of 13.3 million insured persons (or about 25 percent of the total insured) in 1975. There were 10.9 million insured persons (or about 22 percent of the total) under the health insurance society programs in that same year.

The total number of insured persons under both parts of the EHI program was 24.2 million in 1975. With dependents included, total coverage was 53.2 million. (See section of this chapter dealing with administration for explanation of conditions applying to government-managed versus health-insurance-society-managed programs.)

(2) National health insurance program (NHI), a nationwide scheme for all Japanese residents not covered by EHI or one of the special programs listed below. This program was set up primarily for the self-employed, farmers, and fishermen. Essentially a community-based program, it is now compulsory for all local community residents not covered under some other health insurance scheme. This program covers a substantial number of pensioners and other older persons who have not been drawn into industry and who have remained in rural areas (nearly 60 percent of the population over age 60 are under the NHI program). In 1975, NHI insured 43.8 million persons, including dependents (or about 41 percent of total number of insured).

(3) Day laborers' health insurance program, for persons employed by the day, together with seasonal and other temporary workers. In 1975, the total number of insured plus dependents covered under this program was 752,000.

(4) Seamen's insurance, under which coverage has been fairly static from year to year, with about 734,000 persons and dependents presently covered.

(5) Mutual aid associations, set up to cover national and local government employees, workers in public corporations, and teachers. Coverage is about 12 million persons, including both the insured and their dependents.

It should be noted that the term "dependents," when used in the Japanese system, may include ascendants, grandchildren, and younger siblings, as well as spouse and children and any other dependent relative living in the household.

## BENEFITS

It has been said that "the sick person as a rule fares best under a society-managed EHI plan, slightly less well under the government-managed EHI program, and not as well under NHI."[1] Although in principle the range of medical care benefits is basically the same under all the plans described in the preceding section, there are important differences with regard to amount of patient cost-sharing, duration of benefits, provision (or absence of provision) for cash sickness allowances, waiting periods, etc.

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[1] Paul Fisher, "Major Social Security Issues: Japan, 1972." Social Security Bulletin, March 1973: 34.

### A. SERVICE BENEFITS

Service benefits under all the plans consist of:

(1) Physicians' services, in or out of hospital.
(2) All drugs (from a list of more than 7,000 items approved by the Ministry of Health and Welfare).
(3) All approved appliances (except eyeglasses).
(4) Inpatient care in hospitals and clinics.
(5) Nursing care, exclusive of private-duty nursing.
(6) Laboratory services, therapy, and treatment.
(7) Transportation.
(8) Dental care, including most dentures.

Illnesses resulting from the following are not covered: criminal acts of the insured, self-induced disorders, fighting, intoxication, or extreme "profligacy." In cases where an insured person disobeys the instructions of physicians without proper cause, part of the benefits is not given.[2]

### B. EXTRA BENEFITS

In addition to the above, insurers may, at their option, provide other services for the purpose of health promotion and prevention, such as periodic health exams, home visiting services, nutrition clinic services and guidance, and provision of rest homes. Such additional benefits are commonly provided through some of the more financially well-off health insurance societies established by larger industries.

### C. WAITING PERIODS AND DURATION OF BENEFITS

The day laborers' health insurance scheme is the only one of the plans which applies a waiting period to benefits. Eligibility for medical care under this program depends upon the payment of contributions for more than 28 days within the preceding 2 months, or for more than 78 days within the preceding 6 months. The day laborers' program is also unique in its limitation on the duration of benefits—5 years from the first day of treatment. None of the other schemes applies a durational limit on benefits, although certain plans (with the exception of the NHI program) may apply rules governing the period of free coverage after termination of insurance.[3]

### D. CASH SICKNESS ALLOWANCE

Some of the plans also provide cash benefits, including disability allowances for insured persons, funeral grants, delivery grants, and infant nursing allowances for both the insured and their dependents. Under EHI, cash sickness allowances amount to 60 percent (in cases of hospitalization, 40 percent if the insured person has no dependents) of the respective standard renumeration. Cash benefits are subject to a 4-day waiting period and are payable for 6 months (in tubercular cases, 18 months). Under NHI, there is no cash sickness benefit.[4]

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[2] Kenzo Kiikuni, "Health Insurance Programs in Japan." Inquiry, March 1972: 19.

[3] Derick H. Fulcher, "A Study of Some Aspects of Medical Care Systems in Industrialized Countries." International Labour Office, Geneva, 1973: 52–53.

[4] Fisher, p. 34.

### E. COST SHARING

Under the national health insurance plan, there is general cost-sharing by the patient of 30 percent of the cost of services. The 30-percent patient share is paid directly by the patient to the medical facility.

Under the employee health insurance plan, cost-sharing by the insured patient is limited to a fee of 200 yen (about 66 cents) for the first consultation and about 60 yen (about 20 cents) for each day of the first month's hospitalization.[5] Dependents of the insured pay 30 percent of the cost of services, up to a maximum of 30,000 yen (about $100) per dependent "per case" (defined as a complete course of medical treatment, including any hospitalization).[6] This ceiling on dependents' cost-sharing also applies to dependents under the NHI scheme.

Since 1973, persons over age 70 and bedridden persons over age 65 have been eligible for exemption from cost-sharing if their annual income (or that of the family that supports them) is less than certain amounts (in 1973, about 600,000 yen or roughly $2,000).[7]

## FINANCING

Each of the Japanese health insurance programs is financed through separate and different arrangements, as noted below:

### A. EMPLOYEE HEALTH INSURANCE

The government-managed part of the EHI plan is financed through equal contributions from employer and employee. As of October 1973, the combined contribution rate was fixed at 7.6 percent of the employee's total standard remuneration up to a ceiling of 200,000 yen (about $670) a month. The Ministry of Health and Welfare is empowered to increase the contribution rate up to a maximum of 8 percent, with a corresponding increase in the percentage of government subsidy. Total remuneration includes wages, salary, allowances, bonuses, and other income earned by the insured person.[8] There is a national government subsidy of 10 percent of benefit expenditure, plus payment of administrative costs.

Under the plans managed by health insurance societies, the society may charge a contribution rate of between 3 and 9 percent of remuneration within the ceiling applicable to the government-managed program. The employees share cannot, however, exceed 4 percent. The national government subsidizes the program only to a very small extent (in 1974, the subsidy amounted to less than 0.2 percent of total income).

### B. NATIONAL HEALTH INSURANCE

Thirty percent of the cost of this program is borne directly by the insured through the cost-sharing mechanism applied to benefits. The remaining 70 percent of the cost of the program is financed through the national treasury (45 percent) and through a national health insurance tax collected from the insured

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[5] As of December 1974, there were approxmately 301 yen in U.S. $1.

[6] Fulcher, p. 53.

[7] Fisher, p. 35.

[8] Kiikuni, p. 20.

(25 percent). The NHI tax is set according to the financial ability of each household and is collected and accounted for by the local communities.[9] Forty percent of the tax is in proportion to income, 10 percent to property valuation, 35 percent to the number of the insured in the household, and 15 percent on a flat rate. The annual rate is limited to a maximum of 120,000 yen per household (about $400). In 1974, the NHI tax represented 2.8 percent of the taxable income of the households concerned. In addition to the 45-percent subsidy of medical care expenditures, the national government also pays full administrative costs of the program and provides additional grants for poorer local communities and for hospital construction, nursing, and midwife care.

### C. DAY LABORERS' HEALTH INSURANCE

Contributions are shared, in principle, equally between employer and employee and are fixed at a flat rate which ranges from 20 yen to 660 yen per day in accordance with the wage class. The national government funds the administrative expenses and 35 percent of all benefit costs for the plan.

### D. SEAMEN'S HEALTH INSURANCE

This program is part of a total insurance scheme for seamen; thus, the contribution rate covers far more than health insurance. For the total scheme, a ceiling of 200,000 yen a month applies with 33 income grades below it. Government funds meet administrative costs and subsidize part of the expenses for medical benefits.

### E. MUTUAL AID ASSOCIATIONS

Contributions are shared equally by the employee and the employer, which in this case is a public body. Rates are determined by each association and range from 5.4 to 8.8 percent of earnings. Administrative costs are subsidized by the government.

## Administration

The employee health insurance program is administered either directly by the national government through the Ministry of Health and Welfare or by a legally authorized health insurance society. Approval to operate the EHI program through a health insurance society has traditionally been granted only to firms having 300 or more employees; in recent years, only those firms with 1,000 or more employees have been granted such approval.[10] Such a society may be set up by a single employer or by a group of employers acting together. At least one-half of the employees concerned must agree to the establishment of a society, and approval must be received from the Ministry of Health and Welfare.

There are about 1,616 health insurance societies administering the EHI program, under the general supervision of the Ministry of Health and Welfare. Collectively, these societies represent 45 percent of the workers covered under EHI. Most societies serve an individual enterprise, but 257 are general societies organized by the employers and employees of more than one firm. Policy matters are handled by a "conference" consisting of equal numbers of employees and employers, with a board of directors, again with equally representative membership, responsible for executive functions.

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[9] Kiikuni, p. 20.

[10] Fulcher, p. 46.

In addition to direct administration of the day laborers' and seamen's health insurance programs, the national government is responsible for that part of the EHI program not handled through health insurance societies. The Government Social Insurance Administration, through its network of branch offices, operates the program on behalf of some 55 percent of workers covered under EHI.

The national health insurance program is operated through more than 3,200 local authorities (cities, towns, villages, and wards in the city of Tokyo), with central control being vested in the local prefectural government, and ultimately in the Ministry of Health and Welfare. As a parallel to local authority administration, nearly 200 national health insurance associations have been authorized to administer the program on behalf of local residents with occupational or trade affinities. These associations must have at least 300 members and the approval of the prefectural governor. Such organizations include only about 2.6 million of the 44.3 million people covered by national health insurance.[11]

The Japanese system includes various advisory and appeals councils at the national and local levels. A Social Security Advisory Council, whose membership includes vice-ministers, members of the Diet, representatives of employers, employees, medical care providers, and others with experience in the field, advises the Prime Minister on legislation in the area of social security and health insurance. A Social Insurance Council directly advises the Minister of Health and Welfare and the director of the Social Insurance Agency on planning and operation of the health insurance scheme. Citizens' advisory councils are set up at the local level to advise local authorities on the management and operation of the NHI program. Social insurance referees and social insurance appeals committees handle questions and complaints arising under the health insurance (and other State insurance) schemes submitted by insured persons and employers. Final appeal on a decision rendered by a social appeals committee may be made to the courts.

Various reports have noted the unequal performance record between the two parts of the EHI program. Particular concern has been expressed over the need for increasing government subsidization of the government-managed employee system:

> The * * * health insurance societies apparently offer the employee-and particularly his dependents-superior and additional services, are better managed than the other plans, and (probably with the aid of substantial employer subsidies) are able to stay within their budget. About 84 percent of the health insurance societies received in contribution the same or a smaller percentage of payroll as those for the government-managed system. The remainder of these societies obtained from one-half of 1 percent to 1 percent more than the * * * payroll tax * * * that applies to EHI. In contrast, the government-managed employee system requires each year sizable and growing subsidies from general revenues.

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[11] "Outline of Social Insurance in Japan." Japanese Government Social Insurance Agency, Tokyo, 1973:33.

> One reason for the unequal performance of the two parts of EHI may lie in the unequal distribution or risks. The government-managed program, which covers the great number of relatively small enterprises (with less than 300 employees), insures relatively more employees past age 55 with higher morbidity and utilization rates than those insured under the society-managed programs, where persons over age 55 are likely to have been eliminated from the payroll. * * * Insured employees in the government-managed program have a lower average income, and thus pay a lower average contribution. Because their health care needs are greater, however, health care expenditures for this group, particularly for medical care, are higher than for employees in the society-managed plans.[12]

It appears that pressures from large companies, the labor unions, and the National Federation of Health Insurance Societies have thwarted efforts of the government to eliminate the "dual-tract" EHI system. Proposals to unify the EHI and NHI programs have met with even stronger opposition, mainly because such a move would reduce benefits (by eliminating provision for cash sickness payments) and would free the employer from his present obligation to pay one-half the payroll tax under EHI.

In 1972, the society-managed EHI system ended the year with a comparatively sound balance of contributions to expenditures. Of the more than 1,500 approved societies participating in that year, only 284 showed a deficit of funds, amounting to a total for all societies of 53 million yen (about $142,500). In contrast, the government-managed EHI program ended the year with a one-year deficit of 60 billion yen; when added to the accumulated deficit from previous years, the result was a total deficit of 270.6 billion yen by the end of March 1973.[13]

As a nation, Japan has been rapidly increasing its expenditures for medical care in recent years. In 1972, gross national expenditures for medical care totaled 34 trillion yen, a 25 percent increase over the previous year, and representing 4.46 percent of the gross national product in 1972. Of the total expenditures for health, 35.3 percent was spent for hospitalization, 54.9 percent for office and domiciliary care, and 10 percent for dental care. Forty-two percent of the medical care expenditure is spent for medicine, showing that the consumption of medicine in Japan is quite high when compared with countries such as Sweden—15 percent, West Germany—13.5 percent, etc.[14]

## Reimbursement Methods

Medical services covered under Japanese health insurance are available from registered health insurance doctors at "designated health insurance medical facilities," which are hospitals or clinics approved by the governor for participation in the program. Almost all hospitals and clinics in Japan are designated facilities, and nearly all medical doctors are registered with the system. Thus, freedom of choice of physician and institutional provider is virtually guaranteed under the Japanese system.

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[12] Fisher, p. 34.

[13] "Outline of Social Insurance in Japan," p. 3.

[14] Mikio Yamamoto and Junshiro Ohmura, "The Health and Medical System in Japan." Inquiry, June 1975: 48.

More than three-fourths of the hospitals and almost all clinics in Japan are privately owned. Private physicians are generally not permitted to practice in hospitals. (Hospitals have salaried physicians who care for patients in the hospital.) Most physicians have, therefore, set up their own private clinics, many of which have inpatient beds, extensive medical equipment such as X-ray apparatus and laboratories, and ancillary personnel such as nurses and nurse assistants.

Private practitioners usually do not refer their patients to hospitals unless the patient urges them to do so. The patient, however, has freedom of choice in selecting a hospital or clinic for his point of entry into the health system. Practitioners in private clinics commonly perform even minor surgery on the premises.

Several health insurance societies own and operate their own hospitals and clinics. The income from these institutions and that from contributions is often invested in convalescent homes and sanatoria, as well as in rest and vacation centers for the healthy insured.[15]

The general pattern of reimbursement under the Japanese system is that of fee-for-service. Mechanisms such as all-inclusive per diem rates or annual prospective budgets have not been employed for institutional providers in Japan. Hospital income under the health insurance system is governed by a system of "point values" assigned to different services performed in the hospital. The point system establishes a hierarchy of prices for individual services. The value of each point is negotiated in the national Social Insurance Medical Council. In addition to the amount reimbursed through the health insurance system the provider receives directly from the patient the fixed amount of individual cost-sharing applicable under the different plans.

At the end of 1973, the total number of beds in hospitals and clinics was approximately 1.4 million, or about 13 hospital and clinic beds per 1,000 population. The average length of hospital stay is about 34 days excluding psychiatric and tuberculosis cases.[16]

Japan has about 130,000 doctors, or about one physician per 860 people. Even without hospital privileges, private practitioners generally earn higher incomes than hospital staff physicians who are paid according to a full-time fixed salary base. No house staff physician in Japan is permitted to have private beds in the hospital.

Reimbursement for the private practitioner is also on the basis of the point system. Each act of medical care is given a point score, which is determined after due consideration is given to the degree of technical difficulty of the medical service, as well as to economy.

After the patient has directly paid his share of the bill, the remainder is submitted to the Social Insurance Medical Care Fee Payment Fund, in the case of employee health insurance, or to the Federation of National Health Insurance Organizations, in the case of NHI. Both organizations pool the money from each program; and a review is made by a medical consultant before the bill is paid. Unnecessary treatment is sometimes cut off. Payment is generally made within 45 days after submission of the bill.[17]

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[15] Fisher, p. 36.

[16] Yamamoto, p. 45.

[17] Kiikuni, p. 20.

The Minister of Health and Welfare, through the prefectural governors, has the responsibility for overall supervision of the various health insurance payment agencies. The ultimate sanction in cases of serious and deliberate abuse is revocation of the practitioner's or institution's status as a participating provider under the program.

Dentists are paid and evaluated under the same system that applies to physicians. Drug prices are controlled to some extent by the industry and by government price schedules. Most drugs prescribed by a physician are supplied to the patient directly by the doctor himself, and the doctor's daily point score reflects a component for drug prescribing and supplying.[18]

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[18] Fulcher, p. 56–57.

# Chapter 4. Sweden

The Swedish Parliament first passed legislation providing for a compulsory national health insurance program in 1947. However, the effective date for implementation of this legislation was postponed for several years. During this time, studies were conducted to investigate alternative forms of compulsory basic health insurance possibly to be combined with voluntary supplemental group health insurance. Once again in 1953, Parliament approved the creation of a national health insurance program, but delayed the effective date until January 1, 1955.[1]

Since 1955, the entire Swedish population has been covered for a broad array of medical benefits combined with cash payments during periods of working incapacity due to illness or injury. Medical benefits include physician care (small flat-rate fee paid by the patient), hospitalization, and partial reimbursement for prescription drugs and dental care.

About 8 percent of Sweden's gross national product is used for public health and medical care. Costs of the overall health system are financed approximately as follows: (1) combined national and local (county council) government funds, mainly through county council taxation—75 percent, (2) compulsory health insurance contributions from employers and employees—10 percent, and (3) cost-sharing by patients for noncovered or partially covered services—15 percent.[2]

## COVERAGE

All resident Swedish citizens and registered aliens are entitled to medical benefits. Coverage is compulsory—at age 16, all citizens must register with one of the more than 600 local social insurance offices in Sweden responsible for administering the program. Children up to age 16 are covered by their parents' insurance. Foreign nationals are also included—immediately where there are reciprocal arrangements between their country and Sweden (for example, foreigners from other Nordic countries, Italy, the United Kingdom), or after census registration which can take a few months to become effective.[3]

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[1] Odin Anderson in "Health Care: Can There be Equity?" (John Wiley and Sons, New York, 1972) explains the delay as follow: "According to Swedish political protocol . . . a law is not put into effect until the government decides to do so . . . The 8 years were used to iron out administrative and relationship problems with the medical profession." (p. 77)

[2] Joseph G. Simanis. "National Health Systems in Eight Countries." U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics. DHEW Publication No. (SS) 75-11924. Washington, U.S. Govt. Print. Off., January 1975: 87.

[3] Derick H. Fulcher, "A Study of Some Aspects of Medical Care Systems in Industrialized Countries." International Labour Office, Geneva, 1973. Contained in "Medical Care Systems in Industrialized Countries," committee print, 93rd Congress, 2nd Session, Subcommittee on Health, Senate Committee on Labor and Public Welfare, May 1974: 147.

In addition to coverage of medical benefits, all gainfully employed persons earning more than a specified minimum amount, and all homes spouses, are covered for a sickness cash benefit during a period of working incapacity.

## BENEFITS

1. *Inpatient hospital care.*—Unlimited period of maintenance and treatment, nursing care, drugs, auxiliary services, etc., for an individual in a public ward of a public hospital (there are very few private hospitals in Sweden). For hospital inpatients who are receiving a sickness cash benefit (described below), 10 kronor a day are deducted from the sickness benefit.[4] For persons age 67 or over, or those who are drawing on old age pension or full early retirement pension under the National Pension Scheme, hospitalization is payable in full for 365 days in a spell of illness, after which time the patient is liable for a fee of 15 kronor per day of hospitalization.[5]

Reimbursement is also made for related travel expenses and for expenses of an attendant or companion if required. Ambulance service is free; other travel reimbursement is limited to expenses in excess of 8 kronor for the cheapest form of conveyance medically advisable in terms of the patient's health.

2. *Physicians' services.*—The patient who consults a publicly salaried physician pays a flat fee of 15 kronor per office visit. This fee also includes any X-ray exams, laboratory tests, X-ray and radium treatment, and the first visit after referral to another publicly salaried doctor. For a home visit, the patient pays 20 kronor, and for a telephone consultation 2 kronor.

Since January 1, 1975, the patient who consults a private physician is charged a uniform fee similar to that within the public medical care system. In most cases the patient himself pays 20 kronor at the time of his visit, while the local insurance fund office pays the rest of the fee directly to the doctor.[6] Prior to 1975, patients choosing private physicians were required to pay directly the full amount of the physician's fee and be reimbursed by the local social insurance office for 75 percent of an amount stipulated in the Government fee schedule for physicians' services.

When hospitalized in a publicly owned facility, the patient is assigned to a publicly salaried physician or specialist (private physicians do not have hospital privileges) and all costs of physician treatment are covered in full.

For persons seeking outpatient medical treatment, a certain portion of travel expenses (and expenses of a companion when necessary) is also refunded.

3. *Drugs.*—Free of charge when provided as part of inpatient treatment or for treatment of certain specified chronic or serious diseases, whether on an inpatient or outpatient basis. For all other prescribed drugs, the patient pays 50 percent of the cost up to a maximum of 20 kronor per prescription, regardless of the price of the drug.

4. *Dental care.*—Free treatment for children under age 17. In January 1974, a national dental insurance program was initiated, covering all citizens over age 17 for 50 percent reimbursement of dental care expenses; for expenses in excess of 1,000 kronor, the patient is reimbursed for 75 percent of the total

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[4] A Swedish kronor is equivalent to approximately 23 cents in U.S. currency.

[5] Fulcher, p. 149.

[6] "Social Insurance in Sweden." The Swedish Institute, Stockholm, November 1975: 1–2.

amount. Pregnant women can receive reimbursement for up to 75 percent of the actual dental expenditure. Travel expenses incurred for dental treatment are reimbursed if they exceed 15 kronor per visit.

5. *Other institutional care.*—Free care in public mental hospitals and nursing homes on the same basis as care provided in public hospitals (60-day limit in convalescent homes).

6. *Maternity care.*—Medical care, hospital treatment, and travel in connection with pregnancy and childbirth are reimbursed on the same terms applying to other conditions. Public maternity clinics also offer free prenatal and postnatal care.

7. *Medical treatment abroad.*—Costs of medical and hospital care of an insured person who becomes sick while temporarily outside Sweden are reimbursed to a certain extent in accordance with regulations.

8. *Home nursing grants.*—Chronic patients cared for at home by relatives can be compensated for the costs of such care, if it is of the same standard as that offered by a nursing home and is certified by a county medical officer.

9. *Physiotherapy, speech therapy, and prostheses therapy.*—Patient pays a flat charge of 7 kronor for such services.[7]

10. *Sickness cash benefit.*—Generally, the social insurance program reimburses about 90 percent of the income loss in the most common income brackets up to a ceiling of about 70,000 kronor a year. The amount is calculated according to estimated annual income. The lowest sickness benefit paid is 8 kronor per day, which is the basic sickness benefit generally paid to home spouses earning no income from gainful employment. Home spouses and students can also self-insure on a voluntary basis and for a low premium become entitled to receive a maximum total sickness benefit of up to 20 kronor per day.[8]

## ADMINISTRATION

At the national level, the Ministry of Health and Social Affairs gives general supervision to the insurance program. Within the Ministry, the National Board of Health and Welfare is the principal governmental institution for supervising and promoting health and medical care throughout the country. The Board is responsible for the scope and direction of national health policies and for supervision and planning for training of medical personnel, location and construction of hospitals.

However, the bulk of the administrative work for the national insurance system is handled through about 600 local social insurance offices (at one time called "sickness funds") supervised by 26 regional insurance offices with geographical jurisdiction corresponding to those of the county councils. The regional offices are independent, self-governing bodies, centrally managed and inspected by a State body the National Social Insurance Board. Each regional office is administered by a managing committee consisting of representatives appointed by various levels of government.

The 600 local insurance offices manage health insurance contributions and benefits on the local level and are also responsible for administering the national pension insurance (both basic and supplementary pensions) and industrial injury insurance. Prior to the advent of the compulsory national scheme, more than 1,000 government sponsored voluntary sickness funds had insured a large portion of the population (according to one source, about 70 percent of the population in the early 1950s).[9] When the compulsory program was adopted, many of these voluntary funds were converted and their funds absorbed into the national system.

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[7] Ibid. ("Social Insurance in Sweden," p. 1).

[8] Ibid.

Local (county council) government in Sweden plays a major part in the actual delivery of medical care. County councils operate the hospitals and other medical facilities within their jurisdictions and employ the physicians and other health personnel who work in these facilities or as district medical officers. Plans for construction and alteration of medical facilities must meet with approval of the National Board of Health and Welfare. The Board also has the right to control the number of physicians who are given posts in publicly funded health facilities. Only those physicians who work strictly in private practice are not submitted to this control in terms of total numbers.

## FINANCING

Costs of the health system are financed through the following resources: (1) combined national and local (county council) government funds, mainly through county council taxation—75 percent, (2) compulsory health insurance contributions from employers and employees—10 percent, and (3) cost-sharing by patients for noncovered or partially covered services—15 percent.[10]

In 1971, Swedish county councils spent 78 percent of their total budget (approximately $2 billion, or about $250 per person) on medical care, an eightfold increase compared to expenses in 1960.[11] In order to meet the increasing costs of their health responsibilities, county councils have steadily increased their proportional county income tax rate—from 3 percent on taxable income in 1951 to 10.2 percent in 1975.[12] These taxes are combined with communal taxes into a total local income tax payable with the national income taxes once a year.

Health insurance contributions from employers and employees have historically provided only a small part of the total funds expended for the Swedish health system. Combined with national government subsidies (paid out of general revenues) which presently meet about one-third of the costs for the health insurance program itself, health insurance contributions finance only about 10 percent of the overall health system. While health insurance contributions cover both health care and cash benefits, the latter category absorbs the greater share—about 70 percent—of total health insurance expenditures.[13]

Employer contributions are currently set at 3.8 percent of each worker's earnings up to a ceiling of 60,750 a year, an amount which is adjusted periodically to reflect certain economic indicators. Employees and the self-employed pay a flat 300 kronor per year, plus 1.3 percent of income below the same stipulated ceiling applying to employer contributions. This contribution by employees is roughly equivalent to 2 percent of the average industrial wage and is usually collected along with the national income taxes through payroll deductions made by employers on behalf of their employees.[14] Certain insured individuals (for example, pensioners, people over age 65, children under age 16, home spouses, and persons without taxable income) are completely exempt from required health insurance contributions.

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[9] Simanis, p. 80.

[10] Simanis, p. 87.

[11] Joseph L. Andrews, Jr., MD. "Medical Care in Sweden." Journal of the American Medical Association, Mar. 19, 1973: 1370.

[12] "The Organization of Medical Care in Sweden," The Swedish Institute, Stockholm, July 1975: 2.

[13] Simanis, p. 87.

Current annual expenditures by the health system amount to about 12 billion kronor (about $2.6 billion). The rate of average annual increase in total costs for health services for the period from 1968 to 1975 was an estimated 6.2 percent.[15] Between 1970 and 1974, the total overall increase in medical care prices was 40.0 percent as compared with 33.6 percent for all goods and services.[16]

### Reimbursement Methods/Organization of Care

The organization of Swedish health care is highly decentralized. By law, the various county council areas are responsible for providing all country residents with both outpatient and inpatient care for illness, injury, deformity, and childbirth.

For over a hundred years, hospital care in Sweden has been provided almost entirely in public hospitals, which are owned and operated by the counties and municipalities and supported from tax revenues—primarily county taxes with a small grant from the State government. Within each county, a hospital board, consisting of publicly elected members, is responsible for supervising one or more hospitals. In 1963, the county councils took over the national system of district medical officers, who until then had been employed by the national Government. In 1967, the counties assumed similar responsibility for mental health care, thereby gaining uniform authority over the bulk of Swedish medical care.

As noted below, the national Government plays a relatively minor role with regard to the operations and funding of hospital services:

> The central government contributes relatively little to either capital funding or the daily operations of the county and municipally owned hospitals. The leverage the central government has, however, on the hospitals is in its allocation of medical staff throughout the country. The National Medical Board determines staffing ratios and quality criteria. Hence, while a county can actually build or expand a hospital, it better not do so unless it is assured of medical staff by the National Board.[17]

Sweden has one of the highest bed per population ratios in the world—18 beds per 1,000 population in 1974 (in 1970, the ratio was 16 beds per 1,000):

> Of every 16 beds in Swedish hospitals, 8 are in general hospitals, 3 are in medical hospitals, and 5 are in hospitals for the chronically ill. Nationwide planning for the locations, sizes, and types of new hospitals is accomplished by cooperation between the National Board of Health and Welfare in Stockholm, which sets national planning priorities in cooperation with the Ministry of Health and Sweden's 23

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[14] Ibid., p. 88.

[15] S. Ake Lindgren, "Sweden," reprinted from Health Service Prospects, an international survey, published jointly by the Lancet and the Nuffield Provincial Hospitals Trust, London, 1973: 106.

[16] "Statistical Abstract of the United States, 1974," U.S. Department of Commerce, Bureau of the Census, July 1974: 847. U.S. Govt. Print. Off., Washington.

[17] Anderson, p. 112.

> county councils and 3 municipalities, which are directly responsible for financing and running the hospitals within each area. Under the leadership of the National Board of Health, a systems approach evolved to provide adequate health care facilities to meet expanding health needs. With the use of current data for area populations, illness rates, medical facilities, and personnel, and projecting figures for future needs, hospitals are planned according to principles of regionalization, centralization, rationalization, and integration.[18]

For hospitalized patients, reimbursement is based on the number of hospital days for each patient. The total cost per bed per day in most counties varies from about $15 (in chronic disease hospitals or wards) to more than $100 (in neurosurgery, plastic surgery, acute coronary care, renal dialysis). For this, the patient pays nothing, and the local insurance office pays the county council 20 kronor (as of 1/1/76) on behalf of each patient day, regardless of what type of service the patient gets.[19] The remainder of the hospital's cost is borne by the county government.

A recent study of comparative utilization data for 1968 showed that Sweden experienced a higher rate of general hospital admissions per 1,000 population, a longer average length of hospital stay, and considerably more general hospital days per 1,000 population than either the United States or Great Britain. Sweden experienced 137.7 admissions to general hospitals per 1,000 population, whereas the figures for the United States and England were 136.9 and 98.2, respectively. Average length of stay in short-term general hospitals in Sweden was 11.9 days in 1968; for the United States, it was 8.4 days and for England, 11.6 days. In terms of general hospital days per 1,000 population, Sweden far outstripped both the United States and England in 1968—1,569 days versus 1,154 for the United States and 1,132 for England.[20]

Salaries account for 70 to 80 percent of expenditures under the average hospital budget. In 1965, hospital care accounted for 46.9 percent of expenditures for the Swedish health care system, in contrast to 34 percent for the United States and 38.9 percent for England.[21]

Medical services for ambulatory patients are provided through hospital outpatient departments, by district medical officers employed by the counties, and to a lesser extent, by hospital-based doctors practicing outside the hospital for part of the day or week, and by private practitioners. Outpatient services in general practice and specialized care amount to about 20 million visits to the doctor, or about 2.5 visits per person per year. About 50 percent of these visits are outpatient consultations in hospitals, 25 percent are outpatient visits with publicly salaried doctors outside the hospitals (such as the district medical officers), and 25 percent are with private practitioners.[22]

Of the approximately 12,000 active physicians in Sweden, an estimated 10 percent are in strictly private practice. Of these, about 25 percent are over age 65 and many work only part time. As older physicians retire, the number of private practitioners continues to dwindle, as few new doctors appear to be taking their place. Of the 1,200 general practitioners in Sweden in 1969, 400 were in private practice, while 800 were government employed district medical officers. During 1970, in Goteborg, which then had 196 private practitioners, not one new physician entered private practice.[23] The fact that private practitioners do not have hospital privileges in Sweden may contribute to the declining interest in private practice among specialists who normally rely upon hospital facilities for patient care.

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[18] Andrews, p. 1374.

[19] Lars Werko, M.D., "Swedish Medical Care in Transition." New England Journal of Medicine, Feb. 18, 1971: 362.

[20] Anderson, oo. 130–132.

[21] Ibid., p. 121.

[22] Bror Rexed, M.D., "The Role of Medical Education in Planning the Development of a National Health Care System." Journal of Medical Education, Jan. 1974: 29.

Physicians in private practice are under no contractural agreement with the government or the local insurance offices which administer the program. Until 1975, such physicians collected their fee directly from the patient, who was then reimbursed by the local insurance office for 75 percent of the fee, if that fee did not exceed a rate stipulated in the official Government-determined fee schedule. Generally, however, fees of private physicians did exceed the Government scale, in some cases by 30 to 40 percent. In 1970, the average charge of private practitioners was 40 kronor.[24]

Since January 1975, payment which the Swedish patient must meet out of his own pocket when visiting a private physician was set at 20 kronor per visit. This charge was coupled with a fixed fee schedule—then set at 48 kroner and scheduled to go up as high as 70 kronor—designed to cover the rest of the physician's charges under the compulsory health insurance system.[25] Payment of this fee schedule amount is made directly to the doctor by the local insurance office.

Physicians who are employed by the government—as district medical officers, hospital-based physicians, etc.—are allowed to supplement their government salary with private practice and, until the introduction the "7-kroner reform," discussed below, were reportedly earning at least half their annual income from such part-time private practice. Under the provisions of the "7-kroner reform," effective January 1970, the Swedish patient who visited a publicly salaried doctor was to pay a maximum fee of 7 kroner, regardless of the type of consultation (that fee has now been raised to 15 kroner, as noted in the section of this report dealing with benefits). The 7-kroner reform expressly prohibited all doctors employed by the government from receiving any fees directly from patients, whether hospitalized or seen on an outpatient basis in the hospital during the specified hours when the physician is working for the government; thus, the patient now pays the fee directly to the institution or clinic where he receives his care and the government-employed physician is on a regular direct salary. In addition to the 15 kroner patient fee the provider of service (in effect, the institution or other health facility) is reimbursed by the local insurance office 48 kroner for each outpatient visit.

Prior to January 1970, government-employed hospital doctors received a base salary (representing usually about half of their local income) from their employers (the state, county, and local governments) and had as duties to take care of both inpatients and outpatients. For treatment of outpatients, however, physicians were reimbursed directly by patients in accordance with a government-approved fee schedule. Arrangements for the district medical officers were on the same salary-plus-fees basis.

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[23] Andrews, p. 1372.

[24] Alan Wilson, "Outcome of the Standard Medical Fee Reform in Sweden." Royal Swedish Ministry for Foreign Affairs, Information Service, Dec. 1972: 4.

[25] Ragnar Berfenstam and Ray H. Elling, "Regional Planning in Sweden: A Social and Medical Problem." Scandinavian Review, Sept. 1975: 46–47.

Under the new system, publicly employed physicians were placed on a regular salary, and all doctors with equal positions and equal length of service were to be paid the same salary for the same number of working hours, regardless of speciality. The fixed salary scale was increased to compensate for loss of outpatient fees. The work week was also fixed at 40 hours, with agreement reached between the doctor and his employer if local shortages and demands warranted additional overtime. In actuality, most hospital physicians work between 45 and 48 hours per week. Government doctors are still free to practice privately beyond these fixed working hours and be reimbursed on the same basis as full-time private practitioners; however, few government-employed physicians are reported to be doing so.

While it has no part in the day-to-day formal operating authority of the health system, it should be noted that the Swedish Medical Association does participate in reaching central agreements on salary and working conditions through bargaining with the Federation of County Councils on behalf of physicians employed by the county councils in hospitals and as district medical officers.[26]

The Swedish system has developed a form of professional peer review in order to control misuse of the insurance system by fee-for-service physicians;

> The Swedish sick funds employ control doctors to police abuse. If any doctor performs medically unnecessary or excessively repeated medical procedures for money over the statistical norms calculated by the National Insurance Office, the control doctor could ask him to desist. * * * The control doctor can file charges with the Swedish Medical Association, but this action is unusual. The control system is hardly used in Sweden since the economics and ethics of Swedish medicine produces little unnecessary work; because of the severe shortage of doctors, the profession is kept busy doing what is clinically necessary.[27]

The Swedish system has indeed been operating for many years with a considerably lower physician/population ratio than is found in many other industrialized nations. Sweden's physician/population ratio is currently about 1 per 680 population, representing a substantial improvement over the 1 per 1,450 physician population ratio in 1950. National policy is aimed at reducing the physician shortage even further to reach goal of 1 physician for every 450 Swedes by 1980. Medical school enrollment has been so vastly expanded that among 20-year old Swedes one in every 115 is now becoming a doctor. Despite such efforts, however, more than 12 percent of existing public positions remain unfilled, without even a substitute.

About 70 to 75 percent of Swedish physicians are based full time in hospitals, an indication, according to one commentator, of the emphasis that Sweden has placed on institutional care. Apparently, in training greater numbers of physicians, attempts are being made by the central government to increase the supply of physicians without hospital appointments by maintaining a constant number of hospital positions.[28]

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[26] Berfenstam, p. 47.

[27] William A. Glaser, "Paying the Doctor, Systems of Remuneration and Their Effect." The Johns Hopkins Press, Baltimore, 1972: 189–190.

[28] Anderson, pp. 123–124.

Under the new dental insurance scheme, a fee schedule has been established for all dental work provided through public dental clinics and dentists in private practice who join the public program and agree to adhere to the fee schedule. Participation is obligatory for dentists in public dental clinics, but voluntary for private dental practitioners. Private dentists who remain outside the scheme are not reimbursed through the plan, so the patient in this situation pays the full fee himself. The patient who visits a participating dentist will pay the dentist directly, or through billing, one-half of the fee, and the local social insurance office is billed for the remaining one-half.

# Chapter 5. United Kingdom

The British National Health Service came into being on July 5, 1948. The purpose of the program was to "promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physicial and mental health of the people of England and Wales and the prevention, diagnosis, and treatment of illness, and for that purpose to provide or secure the effective provision of services." With the establishment of the NHS, virtually all medical and health services became available to people normally resident in Britain without regard to any insurance qualifications. Although all services were originally free to users, small charges for certain services, such as dental treatment, drugs, and eyeglasses, have since been introduced. The structure of the NHS established in 1948 was substantially reorganized in 1974.

Practically all of Britain's hospitals, clinics, and asylums were nationalized by the NHS and are now owned or controlled by the government. This ownership and control is exercised indirectly through a variety of legally independent bodies; for example, the Regional Health Authorities, which are, however, financially entirely dependent on the central government.

Hospital doctors and personnel are salaried employees. General practitioners are independent contractors who are paid on a per capita basis for all patients who are registered with them; dentists are paid partly on a fee-per-item-of-service basis. General practitioners and part-time hospital consultants can also conduct private practice. Only a small minority of specialists, about 2 percent of general practitioners, and a negligible number of dentists, retail pharmacists, ophthalmologists, and opticians take no part whatsoever in the National Health Service.

The Service is financed mainly through funds from the Exchequer raised through general taxation. Other income is derived from NHS contributions and from charges paid by patients using certain services.[1]

## COVERAGE

All people normally resident in Britain may receive services through the National Health Service without regard to any insurance qualification or prior history of contributions to the Service. Foreign visitors to Britain can be given free emergency treatment, but visitors who come to Britain specifically for medical treatment are expected to pay for it. Certain countries have reciprocal arrangements with Great Britain whereby services are furnished to foreign nationals residing in Britain on the same basis that services are provided to British nationals residing abroad.

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[1] "Health Services in Britain." Issued by Central Office of Information, London, 1974.

## Benefits

The National Health Service pays for virtually the entire range of health and medical care as provided through Regional Area Health Authorities and Family Practitioner Committees. The following services are included, subject in some cases to limited patient cost-sharing as noted below:

### I. PRACTITIONER SERVICE

The Practitioner Service includes the family doctor service, the dental service, the ophthalmic service, and the pharmaceutical service. In the case of the family doctor (or general practitioner) service, patients are required to register with a particular physician and receive most primary services through him. However, the patient is not required to register with a particular dentist, ophthalmologist, optician, or pharmacist. Patients have free choice of these practitioners, and practitioners are also free to accept or reject a particular patient. However, a family doctor must give any necessary treatment to any person who applies to him for treatment when the patient is not on the list of another physician or when treatment is needed in an emergency and the patient's regular doctor is not available.

(a) Through the family doctor service, the professional attention of a general practitioner is made available free of charge to everyone. In order to receive services, each person must register with a particular physician. About 97 percent of the population is registered with family doctors throughout the country. Each general practitioner is allowed a list of 3,500 patients, but the size of the average practice in England and Wales is about 2,400 patients. No charge is made to the patient for either home or office visits. In general the family doctor does not have hospital privileges and must refer any patient in need of inpatient care or treatment to a hospital-based specialist. Patients are free to change doctors, but unless certain conditions apply (change of patient address or location of physician's office, for example) the transfer can be effected immediately or may take up to 14 days.

(b) The general dental service provides all forms of treatment deemed necessary for dental fitness. Unlike the system of open office hours maintained by the general practitioner, the dentist generally sees a patient only by appointment. Unless exempted, patients must pay the full cost of each item of treatment, not including dentures, or £3.50, whichever is the less. There are separate charges for dentures, but a course of treatment including the supply of a denture cannot cost more than £12.00.[2]

No charges are made, however, for clinical examinations, arrest of bleeding, or repairs to dentures. Certain dental procedures require prior approval by the Dental Estimates Board. The following persons are exempt from all dental charges—expectant mothers or those who have borne a child in the preceding 12 months; children under 16; persons under 21 and still in full-time schooling; persons (and their dependents) in receipt of supplementary pension or allowance, family income supplement; and free prescriptions, free milk and vitamins because of low income. Persons over 16 and under 21 who are not in full-time attendance at school are entitled to exemption from charges for any treatment other than the supply or modification of dentures.

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[2] As of December 1975, one pound (£) English sterling was the equivalent of about $2.34 in U.S. currency. One pound consist of 100 pence (p). Ten pence would, therefore, equal about 23 cents, and 50p equals about $1.17.

(c) The general ophthalmic service provides only for the testing of vision and the supply of eyeglasses; treatment beyond this point is performed at an eye hospital or hospital eye clinic. Vision tests are free of charge. The patient pays the cost of prescription eyeglasses. There is a charge of up to £5.00 for each lense, and a charge for a standard pattern frame. For children up to age 16, and older children if they are still at school, lenses are supplied free, provided they are fitted to one of the NHS frames designated as suitable for children. If some other NHS frame is chosen, the usual charge for it must be paid, and if the child is under age 10, the usual charge for the lenses must also be paid. Exemption from such cost-sharing amounts is allowed for certain individuals, e.g. persons with low income, in receipt of certain pensions, allowances, etc., as under the dental service.

(d) Through the pharmaceutical service, everyone receiving treatment under the family doctor service is entitled to medicines and certain appliances prescribed by a doctor as part of that treatment. Patients pay a charge usually amounting to 20 pence for each such prescription item. The following categories are exempt from these charges—children under age 16; men aged 65 or over and women aged 60 or over; expectant mothers and mothers of children under age 1; people suffering from certain medical conditions; persons exempted because of low income; and certain war or service pensioners.

## II. HOSPITAL SERVICES

All forms of hospital care and treatment in general and special hospitals for inpatients, outpatients, and day patients are provided by the Health Authorities. Hospital consultants also provide specialist opinion and treatment, either in hospitals and clinics, or when advisable, at the patient's home. A blood transfusion service, pathological laboratory service, and X-ray service are at the disposal of every hospital. Other hospital services include screening for cervical cancer, prenatal and postnatal clinics, and treatment and supervision of drug addiction. All services are available free of charge to every member of the public, whether or not they use the family doctor service and irrespective of nationality and national insurance qualifications. As a general rule, patients are referred by their family doctors, who make arrangements for specialist advice and the specialist in turn for hospital admission or treatment on an outpatient basis.

Charges for medicines or appliances are made on the same principles and rates as when provided out of hospital. Unless medically required, accommodations above the general ward level are subject to a fixed charge of £ 3.00 a day for a single room and £ 1.50 a day for beds in small wards. At some hospitals, a limited number of "pay beds" are set aside for privately paying patients treated by those NHS consultants who are entitled to engage in private practice. Patients using these beds pay the full cost of the accommodation and services provided and the fees of the consultant.

Treatment for mental disorders is also provided as part of the NHS. Patients can consult their family doctor and receive specialist advice at hospital outpatient clinics, or can enter the hosptial for inpatient treatment without formalities.

Special rehabilitation facilities are provided in the department of physical medicine and occupational therapy at main hospitals and at some special rehabilitation centers not attached to a hospital.

## III. COMMUNITY HEALTH SERVICES

Health Authorities also provide a wide variety of other services, including maternity and child health services, such as family planning, midwifery, and baby care; home nursing; health visitors; vaccination and immunization; services for the prevention of illness and the care and aftercare of illness, including mental disorders; ambulance services; health education of the public; and standard setting and registration of nursing homes. Area health authorities are also empowered to build health centers, which are available for the provision of general medical, dental, and pharmaceutical services, and consultant and other hospital outpatient services. Between 1948 and 1964, the development of health centers progressed slowly with only 21 centers opened in England and Wales. Since that time, however, there has been a marked increase in the number of centers; 468 were in operation as of December 1973, and about 10 percent of general practitioners were working in them.

Despite the broad array of services provided under the National Health Service either free of charge or at a nominal cost, an estimated 2.1 million persons in Great Britain are insured with private health insurance societies. Benefits offered by these societies include such items as care at convalescent homes operated by the societies, small cash benefits during hospitalization, assistance toward meeting the cost of home help, and contributions toward the expense of eyeglasses.

Aside from these benefits, the private plans supplement services paid for under the NHS in several important areas: (1) the private plans allow members to select their own specialist for in-hospital care, whereas the NHS patient generally has no such choice and is assigned to a particular specialist upon hospitalization; (2) the private plans will pay for one of the 4,500 private "pay beds" available in NHS hospitals for persons willing to pay the full cost of their hospital and medical services; the privately insured patient may, therefore, more readily gain admission to the hospital for elective surgery, whereas NHS patients may commonly incur a waiting period of up to 1 year for elective procedures; (3) privately insured patients may also use 1 of the 14 private nursing homes affiliated with private insurance organizations; (4) the private plans will also pay the cost-sharing for "amenity beds" (private beds which may be made available to patients for a small fee, when not needed for medical cases requiring privacy); and (5) private plans may also reimburse for services received from the small number of British physicians who operate a full-time or part-time private practice.[3]

It has been noted, however, that in spite of the existence of private insurance in Britain, private expenditures on medical care represent only a minor portion of total outlays for health care services:

> Overall total expenditure on private medicine is now probably running at the rate of about £30 million (about $75 million) a year; the current cost of the National Health Service is £2 billion (about

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[3] Joseph G. Simanis, "Private Health Insurance in West Germany and Great Britain." Social Security Bulletin, October 1970: 40–41.

> $5 billion) a year. The contrast between these two figures (a ratio of almost 70 to 1) not only puts the size of the private sector into perspective; it also confirms the verdict of the public opinion polls which invariably record overwhelming satisfaction with the NHS.[4]

## Financing

The National Health Service is financed from the following sources: (1) 88 percent from general taxation (Exchequer funds), (2) 9 percent from NHS weekly contributions, (3) 2.5 percent from copayments by patients for certain services such as drugs, eyeglasses, et cetera, and (4) 0.5 percent from miscellaneous sources. The fact that general taxation supports such a substantial part of the NHS has been described as both "the strength and weakness of the political economy model as established in Britain":

> It opens the public purse to the NHS and removes the economic obstacles to the use of medical services, but it does so in a way which also means that health has to battle with a number of other services in a competitive scramble for money * * *. The theoretical advantage of the political economy model health service is, of course, that it allows the central government to allocate resources in what is (hopefully) the most rational, the most effective, and the most democratic way * * *. Thus, the British system allows the government to decide its priorities first between public and private consumption (do we raise more taxes to finance greater government spending, or do we leave more money in people's pockets?); then between different forms of welfare or social spending (do we build more hospitals or more schools?); and finally, between different sectors in the same service (do we concentrate extra resources on accident departments or geriatric beds?). Further, the British system of central government budgeting has now developed a fairly sophisticated 5-year forward projection which provides a framework for deciding priorities between different programs.[5]

The NHS weekly contribution is collected with the social security contribution for cash benefits and is shared between employer and employee; the contribution is earnings related, the employee paying 0.4 percent and the employer 0.6 percent.

A recent study estimates that Great Britain devoted 5.6 percent of its gross national income to health care in 1970, up from 4.4 percent in 1950.[6] Total public expenditures on health and personal social services reached £3.8 billion in fiscal year 1973–74 and are expected to reach £5.2 billion by fiscal year 1975–76. About 20 percent of the health budget goes for payments to the family doctor, general dental, ophthalmic, and pharmaceutical services. Hospital and specialist services account for the largest share—about 75 percent of the total health budget. The remaining amount is absorbed by the area health authorities providing a wide range of health and health-related activities.[7]

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[4] Rudolf Klein, "The Political Economy of National Health." Public Interest, No. 26, Winter 1972: 115.

[5] Klein, pp. 115–116.

[6] Odin W. Anderson, "Health Care; Can There be Equity? The United States, Sweden, and England." John Wiley and Sons, New York, 1972: 138.

[7] Health Services in Britain, p. 55.

During the period from 1962 to 1969, the average annual rate of increase in health expenditures in Britain, adjusted by the average of the Consumer Price Index and wage index changes, reflected an annual growth rate of 5.1 percent.[8] In 1967, 16.6 percent of the total government budget was devoted to health expenditures.[9]

## ADMINISTRATION

Administrative authority for the National Health Service in England is vested in the Secretary of State for Social Services in the Department of Health and Social Security. Corresponding ministerial responsibility for health services varies somewhat in other parts of Great Britain. The Secretaries of State for Scotland, Wales, and Northern Ireland have the responsibility in those jurisdictions. Although there are separate systems for Scotland and Northern Ireland, the general organization and function of the health services are broadly similar throughout Great Britain.

The Secretary of State for Social Services is advised by a Central Health Services Council comprised of nominated members who are office-holders of the principal medical and other professional bodies and selected members representing the various health service professions and the public viewpoint. The Secretary has direct responsibility for the provision on a national basis of all hospital and specialist services, facilities for the prevention of illness, the care of persons suffering from illness and the aftercare of such persons, the conduct of health research, a Public Health Laboratory Service, and a Blood Transfusion Service. He has indirect responsibility for the family practitioner services; five Standing Advisory Committees (on medicine, dentistry, nursing, midwifery, etc.) are under the jurisdiction of the Central Health Services Council.

Decisions regarding allocation of funds and physical resources to regions are made at the central level. Facilities are distributed according to a national plan, thereby allowing for control over the location of expensive units, such as those for cardiac surgery or hemodialysis. The distribution of specialists' posts (hospital consultants) is also made on the advice of the standing advisory committees.

Prior to April 1, 1974, the National Health Service had been divided into three functional branches which covered (1) hospital and specialist services, (2) local authority services (i.e. public health, school health, etc.), and (3) general practitioner services. A massive reorganization of the NHS became effective April 1, 1974, and resulted in the elimination of many of the institutions previously active in administering the service, including regional hospital boards, hospital management committees, executive councils, and boards of governors of teaching hospitals. A single structure now encompasses hospital and specialist services, general practitioner services, and those community health services which were formerly provided by the local authorities. Most of the functions of the 119 executive councils, which formerly administered all problems concerning general practitioner services and other forms of primary care, have been assumed by newly designated bodies called Family Practitioner Committees (described below). Boards of governors at certain specialized postgraduate teaching hospitals will be temporarily maintained.

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[8] Joseph G. Simanis, "Medical Care Expenditures in Seven Countries." Social Security Bulletin, March 1973: 40.

[9] Ibid, p. 42.

Local authorities have also surrendered their National Health Service and school health responsibilities.[10]

In England, 14 Regional Health Authorities have now been assigned responsibility for determining area plans, allocating resources to subsidiary authorities, and monitoring their performance—including the design and construction of new buildings. Members of each Regional Health Authority are appointed by the Secretary of State after consultant with universities, local authorities, the medical profession, and other interested groups, such as the voluntary associations, employers, and trade unions. The Regional Health Authorities are subdivided into 90 Area Health Authorities. The larger areas have been subdivided into 2 or more Districts for a total of about 205 Districts. Area Health Authorities are responsible for assessing needs in the area and for planning, organizing, and administering health services to meet them. All levels will have responsibilities in planning, but day-to-day operations will be supervised primarily on the District level.[11]

Administration of the Family Practitioner Service is the responsibility of 98 Family Practitioner Committees (including 8 in Wales). There is a separate Committee for the area of each Area Health Authority. Fifteen members of each Committee are appointed by local committees of doctors (8 members), dentists (3 members), pharmacists (2 members), and opticians (2 members). Four members are appointed by the local authority and 11 by the Area Health Authority. Among the responsibilities of the Family Practitioner Committees are the following: (1) consideration of application by practitioners to practice in the area, (2) publication of a list of general practitioners in the area, and (3) investigations of complaints against any of these practitioners.

Community Health Councils (numbering about 207) have been established for each District to provide representation of the consumer's viewpoint regarding the structure and effectiveness of the NHS. At least half the Council members are appointed by the relevant local government authorities, and at least a third by voluntary bodies with a strong interest in the health services of the District. The remainder are appointed by the Regional Health Authority after consultation with the local government authorities and others. Councils have the right to secure information, to visit hospitals and other institutions, to bring to the attention of the Area Health Authority local complaints, to send an observer to AHA meetings, and to take other action in consultation with the AHA.[12]

### Reimbursement Methods

National Health Service doctors in general practice are reimbursed according to the number of patients served. A physician may maintain a list of up to 3,500 patients and receive a capitation amount for each patient. In addition to the ordinary capitation fee, there is a higher fee for treating patients age 65 or over. Additional payments are made for practicing in doctor-shortage areas, for accepting responsibility out of normal hours, for night visits to patients, and for expenses associated with a rural practice. A basic fee is provided for each patient receiving complete maternity service through the general practitioner; an extra "out-of-hours" capitation fee is paid for each patient in excess of 1,000 on the GP's list.[13]

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[10] Joseph G. Simanis, "National Health Systems in Eight Countries." U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics. DHEW Publication No. (SSA) 75-11924, Washington, D.C., U.S. Govt. Print. Office, Jan. 1975: 93–94.

[11] Simanis, pp. 93–94.

[12] Simanis, p. 94.

A special allowance is made for doctors practicing in groups. About one-half of all general practitioners now qualify for this allowance. Allowances are made for seniority and for vocational training. Additional fees are paid for services encouraged as a matter of public health, such as vaccination and cervical smears. Reimbursment is also made for the general practitioner's office rent and taxes and for employment of ancillary personnel. Exchequer grants are available for the improving of practice premises and a finance corporation has been set up to make loans for the purchase, construction, and improvement of premises.[14]

Complaints about services received from a general practitioner are investigated by the Family Practitioner Committee. (Before April 1974, a local Executive Council with similar functions investigated complaints.) According to one report, 50 complaints were investigated in the inner London area in 1972 In its findings, the local body decided against physicians in 12 cases (failure or unreasonable delay in making house calls) and in a 13th case, the Committee Executive Council (as it then was) agreed with a government complaint that a physician had falsified a certificate of illness for a worker absent from his job.[15] Dr. Dennis Cook, secretary of the Inner London Medical Committee, does not consider the problem of complaints to be serious or extensive:

> Fifty formal complaints a year in an urban area with 2,000 doctors and 3 million patients is a comfortable figure. I myself practiced for 13 years without even knowing the terms of service in my contract. In all of that time there was one complaint against me and that was dismissed.
>
> * * * The extent of the problem can be seen by the size of the insurance premium to the Medical Defense Union: a general practitioner in Great Britain gets unlimited indemnity for £21 a year ($52).[16]

The local Family Practitioner Committee and the National Medical Practices Committee (appointed by the Secretary of State for Social Services) must approve all applications for location of new general practices. Applications are reviewed on the basis of whether there is need for an additional doctor in the given area. In addition to their NHS practice, general practitioners are allowed to practice privately. The fact that, under the terms of the NHS, the GP or a personally appointed deputy is responsible for the care of patients on his list for 24 hours a day, 7 days a week, 52 weeks a year, somewhat limits the amount of time which can be devoted to handling privately paying patients.

Hospital medical staff are full-time, part-time, or honorary. Paid part-time staff are usually remunerated on a sessional basis at a proportion of the appropriate full-time salary and they are free to accept private patients. Senior hospital consultants (specialists appointed to their positions) earn salaries ranging from £7,536 to £10,689 a year (about $17,600 to $25,000 U.S. currency as of December 1975). Junior hospital staff earn substantially less than these amounts. House officers or interns reportedly earn about £2,200 per year in their first post, with second or third year residents earning from £3,198 to £3,879.[17]

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[13] "Health Services in Britain," p. 16–18.

[14] "Health Services in Britain," p. 16–18.

[15] Nathan Horwitz, "Britain's NHS at 25." Medical Tribune, Nov. 14, 1973:28.

[16] Horwitz, p. 28.

In addition to their salary, consultants are eligible for a limited number of merit awards for exceptional contributions to medicine, the actual amount of the award ranging from £1,506 to £7,947 per year. The basis for determining the awards, and the names of the winners, is not formally announced, but there were reportedly only 124 physicians throughout England and Wales who received the highest award (A+) in 1974. [18]

In 1973, there were about 71,000 active physicians in Great Britain. Some worked part-time in more than one branch of medicine, but, in general, there were 25,000 in general practice and 35,000 in full-time or part-time hospital work. The remainder were employed in university, industrial, military or public health work. About 16,000 were junior hospital staff (the equivalent of residents and interns) and 12,500 were specialists at the consultant grade. The doctor-population ratio in Great Britain was 1 per 1,010 in 1950 but by 1973 this ratio had improved to 1 per 766.[19]

The British Medical Association estimated that as of April 1973, the average net income of the general practitioner was $14,300 annually. For top specialists, net earnings averaged $19,000. These figures include only earnings from fixed government salaries or contracts for NHS work. As noted earlier, part-time consultants are permitted to have private patients, bringing in anywhere from $5,000 to $20,000 more per year, and many general practitioners make extra money by contracting to serve as insurance, school, or hotel physicians.[20]

As indicated in the section of this report dealing with the administration of the NHS, the medical profession is well represented at most levels of decision-making. Commenting on the influence of the medical profession on public policy, one author makes the following points:

> The influence of the medical profession on public policy has, if anything, been increased by the NHS. Indeed it is tempting to diagnose a kind of tacit agreement. On the one hand, under the British NHS the doctor in effect administers the rationing system. It is up to him to decide who should use the scarce resources available—who should be treated in the hospital, who should go on the waiting list, and so on. In short, the British system is one of rationing by medical discretion (though obviously the scope for this discretion is affected by the availability of resources). The fact that the British doctor has no personal financial incentive in offering treatment may help to explain the ability of the NHS to contain costs; conversely, though, the system doesn't offer the doctor any monetary incentive to improve efficiency. * * * Even more important is the medical profession's ability to dominate the execution of national policy and so to make the administrators dependent on its good will. Paradoxically, the medical profession is most independent and powerful where its position appears least so. Hospital consultants are salaried employees, yet dispose of their beds with complete freedom from any control; there is nothing in Britain which resembles a medical audit or any form of quality or efficiency control. General practitioners, who bitterly fought

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[17] Unpublished government data made available through the Information Division, Department of Health and Social Security, London, August 1974.

[18] Ibid.

[19] Ibid.

[20] Horwitz, p. 28.

> salaried status and are independent contractors, are subject to rather more, though still slight, supervision over such matters as the amount of drugs prescribed. Finally, dentists, who in theory ought to have the greatest freedom since they work on a fee-for-service basis, are in fact subject to the most detailed checks on the quality and amount of work performed. In other words, the British experience suggests that doctors can achieve most power when they infiltrate the health service system itself; by insisting on "independence," general practitioners have remained on the periphery of the NHS in every sense, isolated from the hospital service and from power.[21]

Other practitioners under the NHS are reimbursed in a variety of ways. Dentists practicing in their own offices are reimbursed on a free-per-item-of-service basis according to a prescribed scale of fees, which is only partially covered by direct charges to patients. Most dental treatment, including fillings and root treatment, extractions not requiring replacement by dentures, and ordinary denture repairs, may be given without approval of any outside authority' extensive and prolonged gum treatment, some dentures, crown and inlays, and special appliances and oral surgery require prior approval by the Dental Estimates Board, consisting preponderantly of dental practitioners. Dentists are free to accept private patients if they wish.

Ophthalmic practitioners and opticians are paid prescribed fees for vision tests; opticians who dispense eyeglasses are paid according to the number and types of eyeglasses supplied, including a dispensing fee for professional service, together with the cost of the eyeglasses and some addition to cover the risk of breakages. Pharmacists dispensing on their own premises are paid on the basis of the prescriptions they dispense. Almost all pharmacies in England and Wales take part in the NHS. In addition to the direct charge to the patient for each prescription, pharmacies are paid for each prescription the cost of the ingredients, a percentage on cost, a container allowance, and a professional fee.[22]

The Regional Health Authorities are responsible for reviewing the distribution, delivery, and costs of services, and for the improvement and construction of facilities. Based on its review, each Authority submits an annual estimate of expenditure to the central government for approval. Within the overall budget allocated to each regional or area authority, it may decide upon the number and kind of personnel, but it has no control over salary ranges, which are established nationally and are, with few exceptions, uniform throughout England and Wales. The day-to-day operation and fiscal management of individual hospitals are under the Area Health Authorities, which control staffing, facilities, and equipment, and report to and are monitored by the Regional Health Authorities.

In England in 1973, the average length of hospital stay for non-psychiatric cases was 13.5 days. The hospital bed occupancy rate for non-psychiatric cases in England for the same period was 76.7 percent.[23] In 1972, there were 9.02

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[21] Klein, pp. 122–123.

[22] Health Services in Britain, pp. 19–20.

[23] "Health and Personal Social Services Statistics, 1974." Her Majesty's Stationery Office, London, p. 72.

available hospital beds per 1,000 population in England, a slight decrease over previous years coincident with both an elimination of obsolete installations and a more intensive use of inpatient facilities. The number of inpatient cases treated per available bed rose from 9.42 in 1962 to 12.51 in 1972, an increase of some 33 percent.[24]

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[24] Derick Fulcher, "Medical Care Systems in Industrialized Countries." Contained in a committee print, Senate Labor and Public Welfare Committee, Subcommittee on Health, 93rd Congress, 2nd Session. U.S. Govt. Print. Office, May 1974, p. 90.

# Chapter 6. Union of Soviet Socialist Republics

Public health and medical services in the Soviet Union are considered a responsibility of the State and a function of government, and as such, are provided as a public service. Soviet socialized medicine is a nationalized health service and not a health insurance scheme. Personal medical services are available to the entire population at no direct costs (with a few minor exceptions) at the time of use. The system is financed entirely by and through the State from taxation, and costs are represented as part of the different national, Republic and local budgets.

The origins of the present structure of the Soviet health system can be traced to 1918, when a Commissariat of Health Protection was established by decree of the new Bolshevik government. The Commissariat was charged with responsibility for administration of the nation's health system. In the U.S.S.R., socialized medicine is officially defined as a socialist system of governmental and community measures having as their main purpose the prevention and treatment of illness, the provision of healthy working and living conditions, and the achievement of a high level of work capacity and long life expectancy.

Responsibility for administration of the health system rests with the Ministry of Health and its counterpart ministries in the constituent Republics and the health departments at the different administrative levels, down to the localities. Health services are organized in a series of tiers of increasingly sophisticated medical treatment as one moves from local facilities to those that serve larger areas.

According to one source, total direct expenditures by the Soviet Government on health care represent an estimated 3.5 percent of the gross national product.[1] Between 1969 and 1976, the Soviet Union's health budget rose by about 32.5 percent (from 8.6 billion to 11.4 billion rubles). It should be noted that the total amount allocated by the Government for health purposes does not include moneys expended for scientific research, medical education, social security payments, or rest homes or sanitoria. Nor does it include amounts expended by collective farms, factories, plants, and other organizations which are required to provide their employees with health services in their own health facilities. The amount budgeted for such purposes in 1976 is 2.7 billion rubles.

## COVERAGE

The entire population is provided with comprehensive health services.

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[1] James E. Muller, M.D., et al., "The Soviet Health System—Aspects of Relevance for Medicine in the United States." New England Journal of Medicine, Mar. 30, 1972: 698. The authors note that this figure for percentage of GNP spent on health care should be considered in light of the fact that different methods are used by other countries in calculating the GNP, that there is some uncertainty over the magnitude of health activities supported by sources outside the Soviet health budget, and that the system is notable for the low pay of health personnel in relation to other Soviet professionals.

## BENEFITS

The Soviet health system is designed to make virtually every kind of health and medical care available and accessible to all. All medical care is free of charge, except for some nominal payment required for drugs, dentures, eyeglasses and certain surgical appliances—but almost one-half the population are exempt from these charges (i.e., children, invalids, people afflicted with certain medical conditions, war veterans, etc.)

Great emphasis is placed on preventive care and health education of the public. It has been estimated that 80 percent of Soviet citizens attend their local polyclinic (comprehensive outpatient facility) at least once every year, and that the average annual attendance rate is between 7 and 10 attendances per person at risk.[2] Immunizations and other prophylactic measures, physical exams and screenings, rehabilitation and physiotherapy are provided through the system.

There is generally no free choice of physician. People within a given geographical neighborhood (or "uchastok") are allocated to the physician who has been assigned for the particular locality.

In terms of health facilities, the U.S.S.R. has 91 medical schools, 26,000 hospitals, 38,000 establishments providing medical ambulatory-polyclinical aid, 3,000 emergency aid stations, and 5,200 sanatoria. In 1975, the Soviet Union had close to 12 hospital beds per 1,000 population; the official policy is in favor of increasing this ratio still further. In 1972 the average general hospital stay was about 16 days, twice the U.S. average.[3] Excluding hospitalization for pregnancy, labor, and related conditions, the hospitalization rates were 148.4 per 1,000 population.[4]

## FINANCING

The Soviet health system is financed entirely by the State through taxation. Taxes are channeled into the State treasury and reallocated to the health sector, as well as to other sectors of the economy, through three main sources: (1) Payments made by industrial organizations from their profits, or the difference between the cost of production (including salaries) and the value of the output; (2) the income tax, which is a minor source of revenue; and (3) the turnover tax, a major source of revenue which is essentially a sales or excise tax applied to all consumer goods in the Soviet Union. Costs of the health system are represented as part of the national, Republic, and local budgets.[5] In 1971, health services accounted for 7.5 percent of the total Soviet budget.

## ORGANIZATION AND ADMINISTRATION OF HEALTH SERVICES

The administration and organization of the Soviet health services corresponds exactly to the general structure of the central and local government because they are integral parts of central and local government services. Starting with the Ministry of Health and extending down to the smallest units, the pattern is similar in form and shape. The following is an outline of the administrative structure of the Soviet health system.

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[2] John Fry, Medicine in Three Societies; a Comparison of Medical Care in the USSR, USA and UK. American Elsevier Publishing Co., Inc., New York, 1970: 67.

[3] "Medical News Around the World," Medical World News, Feb. 4, 1972: 12 M.

[4] T. M. Ryan, "Primary Medical Care in the Soviet Union," International Journal of Health Services, May 1972: 250.

[5] Mark G. Field, Soviet Socialized Medicine. The Free Press, New York, 1967: 190.

### 1. THE MINISTRY OF HEALTH

At the highest level of government, the central administrative unit is the Council of Ministers of the Union of Soviet Socialist Republics and the Minister of Health is a member of the Presidium or Cabinet. The Ministry of Health is located in Moscow and is under the direction of the Minister of Health, who is always an eminent practicing physician.

The Ministry of Health of the U.S.S.R. is responsible for long term planning and policy decisions on health services for the entire population, including the calculation and publication of norms and standards for resources and qualitative standards for medical care throughout the country. The Ministry of Health is also responsible for the nation's health budget, and for defining priorities in keeping with the overall goals and objectives; in that responsibility, it collaborates closely with the Central Planning Council.

The Ministry is also responsible for 10 of the 85 Soviet medical schools and for 13 postgraduate institutes. The others are under the direction of local Republics.

The staff of the Ministry of Health is about 900, of which two-thirds are physicians. Although this would seem a small staff for an organization responsible for directing the health care of a nation of 250 million, it is appropriate because the U.S.S.R. Ministry of Health is essentially a policy-formulating body and is not concerned directly with local administration which is the responsibility of the local Republics. It should be noted, however, that although the various Republics have some autonomy in administering health services within their boundaries, the Health Ministry of the U.S.S.R., through its power of health legislation, can invalidate any health legislation enacted at the Republic level if such legislation is found to be inconsistent with or contradictory to legislation adopted at the national level.

### 2. MINISTRY OF HEALTH OF THE SOVIET REPUBLICS

The U.S.S.R. is divided into 15 Republics, each having its own ministry of health, headed by a minister who is appointed by the Central Soviet of the Republic on the approval of the Minister of Health of the U.S.S.R. The Republics vary in size and in population and in the nature of their geographical and medical problems, extending as they do from Western Europe to the Arctic.

The Republican ministries have more departments than the Health Ministry U.S.S.R., and their administrative structures are more complex, reflecting greater direct responsibility for the administration of health services. For example, the administrative structure of the Health Ministry of the Russian Soviet Federated Republic (RSFSR) includes the following departments: Administration for Medical Preventive Assistance; Administration for Preventive Assistance for Children and Mothers; Administration for Medical Schools; Administration for Capital Construction; Administration for Specialized Sanitoria; Pharmaceutical Administration; Sanitary-Epidemic-Control Administration, Administration for Scientific Research Institutes of Epidemiology, Microbiology, and the Production of Vaccines and Sera, as well as the usual administrative and housekeeping departments such as personnel and financial administration.

Despite this apparent operating autonomy, the budgets of each individual Republic are derived from central government funds and are not based on any local taxation.

### 3. REGIONAL HEALTH DEPARTMENT

The detailed administration of the Soviet health system is carried out at the regional level through regional health departments (oblasts). The size of a region may vary from 1 to 5 million persons and large cities such as Leningrad with a population of more than 4 million function as a single region.

Each region has an executive council composed of members elected by the population. The chief medical officer of the region is an elected member of that council with the responsibility for all the health services and institutions in the regions, including all polyclinics and dispensaries, hospitals, and public health services. The chief medical officer is assisted by a number of physicians called chief specialists who head the various speciality sections. These speciality sections in most instances include: therapy, surgery, gynecology, obstetrics, epidemic diseases; and the chief specialists are responsible for the level and quality of the services rendered in their speciality areas. For example, the chief specialist in surgery is responsible for the organization and quality of surgical work in the region. In discharging that responsibility he maintains contact with and supervision of all surgeons and is responsible for insuring adequate postgraduate training.[6]

### 4. DISTRICT HEALTH SERVICES

Although the region has the responsibility for the direct administration of the delivery of health services, it is much too large for effective day-to-day management of the various health services. Regions are, therefore, divided into districts (rayons) serving populations of 40,000 to 150,000. The district may have a single central hospital, but there are frequently several hospital units, a number of polyclinics, and at least one public health unit. All of these health facilities are under the direction of the chief physician of the district, who is usually the senior physician of the central district hospital.

### 5. MICRODISTRICTS

The whole system of Soviet health care rests ultimately on the concept of neighborhood areas (microdistricts) where personal care of the people is provided by small teams of medical and paramedical workers.

Microdistricts (uchastoks) in an urban area usually consist of about 4,000 adults and children; the boundaries of microdistricts must be periodically reexamined and redrawn to reflect changes in population. Under the microdistrict system, a person is assigned to a health territorial unit on the basis of his residence; should he move to another area, he is assigned to a corresponding microdistrict. As might be expected, in the countryside, microdistricts are generally much larger, geographically, than in the cities. In addition, many rural microdistricts have their own small hospitals to insure inpatient services for the people, particularly when distances are great and there are transportation difficulties. On the other hand, urban microdistricts, characteristically, have no medical facilities of their own; such facilities are usually placed at the district level.

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[6] Fry, pp. 29–33.

There are usually 10 microdistricts in each district. The ideal district is one with a population of 40,000 divided into 10 microdistricts with a population of 4,000 each.

### 6. ORGANIZATION OF HEALTH CARE IN THE INDUSTRIAL SETTING

The majority of the Russian population receive their basic health care services in the territorial network of districts and microdistricts. In addition, however, there are networks based, not so much on geographical location, as on occupation. Industrial plants and organizations are required to build and maintain health facilities out of their own budgetary resources. In the factories, the shop plays a role equivalent to the microdistrict. The workers in a single shop constitute a panel of potential patients, with each panel consisting of from 1,000 to 1,500 workers. The health personnel who service these workers are appointed, paid, and supervised by the local health departments to provide a degree of uniformity in the delivery and standards of health care.

### 7. OTHER RESIDUAL HEALTH SYSTEMS

In addition to the industrial health care system, the U.S.S.R. has a number of other closed panels of patients related to status. There are a number of health facilities which are designated for the use of the members of the Soviet political elite, including the Kremlin clinics and hospitals. These facilities are also often those to which prominent Communist party members from outside the U.S.S.R. are treated when they come to Russia for medical care. Similarly, members of the Soviet Academy of Science, which is composed of the top Soviet cultural elite, along with their families, have access to health facilities outside the regular health system.[7]

### 8. DISTRICT POLYCLINICS

No description of the organization of the Soviet health system would be complete without a discussion of the nature and function of the district polyclinic. Essentially, the district polyclinic is a comprehensive outpatient facility and health center designed to provide a broad range of health services with the exception of inpatient hospital care. Patients whose conditions require hospitalization are directed to the appropriate facility by the personnel of the polyclinic. (In those districts where there is a district hospital, the polyclinic is designated as an administrative subdivision of that hospital.) The personnel in the polyclinic are appointed and paid by the municipal health department in the cities, and by the rural health department or the district hospitals in the countryside.

The polyclinic may be housed in a building of its own or it may share space in a building used for nonmedical purposes—for example, an apartment building. It usually consists of a reception hall where the patients report for appointments. To facilitate continuity of care, the polyclinic maintains the records for patients in the service area, classified by microdistrict and by address. Additional space in the polyclinic is devoted to treatment rooms, procedure rooms with diagnostic and medical equipment, and laboratories for diagnostic tests.[8]

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[7] Field, pp. 87–95.

[8] Field, pp. 88–90.

The size of polyclinics and the services they provide vary with the size and geography of the area they serve. In large cities such as Moscow and Leningrad, there are specialized clinics for children, adults, and for disease entities such as women's diseases, tuberculosis, dental surgery, and skin and venereal disease. In smaller cities, there is generally an all-purpose polyclinic that provides care for the entire population; even in these facilities, the treatment of children, adults and various disease categories is divided among separate physicians. There is no evidence of a form of family practice which would provide for the treatment of an entire family in the polyclinic setting; despite the existence of the polyclinic, the delivery of basic health services can be so fragmented that an individual may be under the care of three or more physicians who are located in different buildings.

In large cities an adult polyclinic may serve a population of from 40,000 to 60,000. Polyclinics devoted to the treatment of children in cities of comparable size may provide care for a patient population of from 15,000 to 20,000 children under the age of 15. In addition, a polyclinic specializing in the treatment of women may include the service areas of a number of adult polyclinics and draw from a patient population of as many as 250,000 women.[9]

In general, all urban polyclinics are built and organized along the same lines. A description of one polyclinic in Moscow, serving a patient population of about 41,000 indicates that the facility has a staff of 90 physicians, 133 paramedical workers, 20 clerical assistants and 15 cleaners. The range of specialities housed at that facility include urologists, pathologists, radiologists, gynecologists (for diagnostic work only), ophthalmologists, and dental surgeons, along with a complement of surgeons, specialists, therapists, and other health professions.

Office hours at the Moscow polyclinic, as is the case with all other counterpart facilities, are from 8 a.m. to 8 p.m. In addition, the polyclinic has two emergency units on call during the entire day, with a small emergency room for minor traumas. The workload of the polyclinic is between 1,000 to 1,500 visits a day, and 20 to 25 evening and night visits.[10] Also characteristic of urban polyclinics, the facility has the responsibility for a number of local factories, each with an industrial health unit, and each staffed by the polyclinic with a physician and four feldshers (paramedical workers under the supervision of a physician).

## REIMBURSEMENT METHODS/CONDITIONS OF PRACTICE

The physician is trained at State expense and works as a salaried State employee in a State-owned facility. The State establishes conditions of work, norms of patients to be seen, and salary levels. While private practice still exists, it is frowned upon ideologically, and it is slated eventually to disappear. Even the few doctors who have a private practice (mainly stomatologists, venereologists, and a small number of other physicians acting in a "consultant" capacity) must have at least one full-time job with the State. There are also a few paying polyclinics, somewhere between private and State-owned facilities, where for a relatively modest fee a patient can avail himself of a consultant or specialist. There are no private medical facilities, such as hospitals, clinics, or sanatoria.

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[9] Fry, pp. 105–108.

[10] Ibid.

As is the case with all other employed persons in the U.S.S.R., doctors are paid salaries drawn from the general revenue of the Government. Each economic sector has its own wage scale and Soviet doctors are paid according to the scale for all employees in health. Positions on all Soviet pay scales are based on the characteristics of the job and of the individual—"arduousness," education, skill, and other personal qualifications, managerial or other responsibilities, length of service of the incumbent, importance of the industry in the entire economy, and geographical location of the medical facility. The categorical wage decrees embodying the pay scales for all Soviet workers are issued by the Council of Ministers and are binding on all Government agencies, trade unions, and employing organizations.

Under the present salary scale, directors of hospitals and other medical facilities receive higher rates on the average:

> For example, the chief physician of an urban hospital with a staff of 200 physicians receives a base pay of 225 rubles per month, whereas a physician practicing in the hospital for less than 5 years receives a base pay of 90 rubles per month. With 30 years of professional service the chief physician's base pay would increase only to 230 rubles, whereas the practicing physician's base pay would increase to 165 rubles per month.[11]

Chiefs-of-service in hospitals and in polyclinics receive supplements to their base-pay rates according to the size of their departments, size in this case being determined by the number of physicians working in that department. Supplements to the base pay of all physicians are also provided on the basis of level of professional achievement, the difficulties or hazards of working conditions, and territorial location:

> Physicians who are certified to be in the "higher-qualification" category on the basis of their continuing education progress receive an additional 30 rubles per month. A "Doctor of Medicine" receives a 20-ruble supplement, whereas an "Honored Physician of the Republic" receives a 10-ruble supplement. Base pays are increased by 20 percent for night work and 15 percent to 30 percent for work with radiologic equipment or patients with tuberculosis. Physicians who work in isolated rural areas or the far North receive 30 percent to 100 percent increases in their base pay.[12]

A major exception to the customary pay scale for Soviet physicians has been made for professors in medical institutes and clinical scientists who have traditionally been paid on the basis of a separate salary scale. In the past, these differentials were the source of considerable disparities in salary between the academicians and scientists on the one hand and the practitioners on the other. For example, in 1962, the 103 members of the Academy of Sciences held 1,037 jobs, and received a salary from each job. A number of reforms, including reductions in the pay of medical school professors and a prohibition against a physician receiving more than one salary, have reduced the differentials in pay. However, members of medical faculties can still supplement their income by clinical practice and writing.

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[11] Muller et al., p. 697. A rubble is worth about $1.32.

[12] Ibid.

According to most commentaries on the conditions of the medical profession in the Soviet Union, physicians are not highly paid in relation to other professionals in the Soviet Union:

> The urban hospital physician with less than 5 years' service and a base pay of 90 rubles per month receives the same compensation as a librarian with a college education but less than 5 years' service, a secondary school instructor with between 5 and 10 years of service, or the principal of a secondary school with less than 280 students and less than 5 years' experience. The dean of a university with more than 3,500 students who is a professor receives 600 rubles per month as base pay.[13]

In return for his salary, the Soviet physician is expected to work 6 hours a day, 6 days a week, which has always been the work schedule for the Russian urban professional. Some urban doctors and all rural doctors must be available for emergency duty, but most polyclinics and hospitals have their own separate emergency staffs. The volume of work per primary physician per week (the weekly number of physician/patient consultations) averages 120 visits, including polyclinic consultations and home visits.[14]

Roughly 70 percent of the Soviet Union's 830,000 doctors are women. The USSR has one of the highest ratios of doctors per population in the world—in 1975, there was 1 physician for every 308 persons (comparable figures for the U.S. in 1973 were 1 per 641 persons). Dentistry, or "stomatology," is considered a medical specialty, rather than a distinct profession; thus, the physician total does include doctors of dentistry. "Middle medical workers," (i.e. nurses, feldshers, etc.) whose responsibilities and authorities are below the level of a physician's training, numbered about 2.5 million in 1975, or a ratio of about three auxiliary workers to every doctor (the comparable ratio in the U.S. is about 8 to 1).

Upon graduation from medical school, four out of five physicians practice in places assigned by the Ministry of Health. The remaining 20 percent go on for further academic specialization. Practicing physicians are encouraged to have some form of advanced training every 3 years if they practice in rural areas, and every 5 years if they work in urban areas. Some advanced training is not obligatory by law, but incentives are provided in the form of increased salaries and more desirable work assignments after training. And there is substantial physician participation; for example, in 1973, nearly 70,000 physicians took part in some form of advanced training.

In addition to programs for advanced study, Soviet health authorities have instituted a program of continuing postgraduate education and training. Under such programs, formal course and practical instruction are available to physicians who have been practicing for a number of years. The purpose of the continuing education program is to provide physicians in community practice, particularly in rural areas, with knowledge of advances in modern medical practice.

There are substantial variations in the distribution of physicians among the various constituent Republics and particularly between rural areas and the large urban centers. For example, the ratio of physicians to population ranges from 34.6 per 10,000 in the Georgian Soviet Socialist Republic to 14.9 in the Tadzhik Soviet Socialist Republic.[15]

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[13] Muller et al., p. 697.

[14] John Fry, "Structure of medical care services in the USSR." International Journal of Health Services, May 1972: 242.

Similarly, Moscow and Leningrad, the two largest Soviet cities and the most important administrative, medical and research centers, have the highest physician to population ratio in the country. The most recent statistics indicate that Moscow has 62.5 physicians per 10,000 people. The supply of physicians falls off substantially in the provincial centers, the outlying districts, and particularly in the countryside. The ratio of physicians working full-time in rural areas to the population they serve has been indicated by Soviet health authorities to be as low as 5.4 physicians per 10,000 population.

Efforts to increase the number of physicians available to rural inhabitants have not proved very successful. Most Soviet physicians, upon completion of their medical education, are assigned to serve in medically underserved areas for from 3 to 5 years. Attempts to provide financial incentives to physicians to remain in practice in underserved rural areas through differentials in pay and more generous retirement provisions have not been sufficient to motivate many physicians to practice in the countryside.

It has been suggested that adequate pay differentials cannot be introduced into the Soviet system because the salary structure is based on the administrative clinical hierarchy. A pay differential sufficient to encourage rural practice could conceivably result in a rural physician with no administrative responsibilities being paid a salary at least equal to that paid to a service chief in a hospital. To date, however, the Soviet salary scale has not permitted such a major deviation from the rank hierarchy.[16]

Because of the demand for medical personnel and particularly the shortage of doctors in rural areas, the role of the feldsher is an important one in the Soviet health system. The feldsher has been a part of the Russian health care system for several centuries. Feldshers (from the German feldshere, meaning field barber or company surgeon) were originally introduced into Russia by Peter the Great in the 17th century to serve the military. In the 19th century, many retired military feldshers began practice in the countryside where they became the major source of medical care for the peasantry.[17]

The present feldsher is a qualified paramedical worker who has undergone a special 2- to 3-year training course and who works as part of a health team under the supervision of a physician. Although feldshers are still chiefly found in rural areas, they also work in urban communities in such specialized areas as emergency care, mental illness, and occupational health and preventive care.

In theory, the feldsher is only a doctor's assistant, not entrusted with medical functions and medical decisions:

> The fact of the matter, however, is that under conditions where there is no physician around, or when no physician is available, the feldsher will fulfill many medical functions, except perhaps for routine surgery * * * In some respects the feldsher's functions in rural districts resemble those of the public health nurse in the more isolated districts of the United States.[18]

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[15] John D. Cooper, M.D., "Education for the Health Professions in the Soviet Union." Journal of Medical Education, May 1971: 412–415.

[16] William Glaser, "Paying the Doctor." Johns Hopkins Press, Baltimore, 1970: 232–234.

[17] Field, pp. 127–128.

[18] Ibid., p. 127.

Feldshers in rural areas have fewer people under their care than do micro-district (uchastok) doctors, usually less than 1,000 persons. Their work consists primarily of simple and straightforward medical and minor surgical matters, preventive care and immunization, and aftercare supervision of chronic illness. Soviet health authorities indicate that 20 to 30 percent of all medical students are former feldshers and that every year 2 to 5 percent of the feldshers enter medical school to become physicians.[19]

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[19] Cooper, pp. 412–415.

# Chapter 7. West Germany

Germany's system of social health insurance was established in 1883, at which time about 15 percent of the population (primarily low-income workers) was first legally required to obtain membership in sickness insurance funds. Today the system encompasses almost 90 percent of the population. More than 1,800 semiautonomous sickness funds administer the decentralized program, under the general supervision of the Ministry of Health.

The statutory health insurance program provides a wide range of designated benefits, including service benefits for medical and dental treatment and drugs, and sickness cash benefits during periods of unemployment due to illness. In addition to the required benefits, sickness funds may at their own option provide supplementary benefits.

In general, employers and employees make equal contributions to the program in fixed amounts ranging from 4 to 5.5 percent on both worker and employer of total insurable wages up to DM 22,500 per year.[1] The actual contribution rate varies from fund to fund with the average combined rate reaching 9.4 percent by January 1974. The Social Pensions Insurance Funds pay contributions on behalf of retired and disabled pensioners and the Federal Institute for Labor makes contributions on behalf of persons receiving unemployment benefits or assistance and maintenance allowances.

## Coverage

Approximately 17.8 million employees and 7.9 million pensioners are compulsorily insured under the German program. About 4.6 million persons are voluntarily insured. Along with 24 million dependents of these people, the total number of insured persons represents almost 90 percent of the total population. Included among the 90 percent of the population covered by health insurance are the following recipients of social benefits who receive their medical treatment through statutory health insurance (acting on behalf of other branches of the government):

War victims and their dependents, war survivors.
Recipients of social aid, based on local arrangements.
Victims of industrial injuries and diseases.
Recipients of reparations benefits.
Returnees.

About 4.6 million persons are privately insured. Persons with no insurance coverage total about 1.4 percent of the population.[2] All wage and salary workers and self-employed persons whose earnings are below a stipulated ceiling (DM 22,500 a year as of January 1974) are compulsorily insured. All blue-collar workers (manual workers in specified job classifications) are compulsorily covered regardless of whether their income exceeds the stipulated ceiling. Unemployed persons receiving unemployment benefits and pensioners are also insured on a compulsory basis.

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[1] As of December 1975, one DM (Deutsche Mark) equaled about 40 cents in U.S. currency.

[2] Survey of Social Security in the Federal Republic of Germany. Federal Minister for Labor and Social Affairs, Bonn, 1972: 125–129.

Prior to 1971, salaried white-collar workers and the self-employed who earned more than the stipulated ceiling were not eligible to participate in the program. In January 1971, new regulations allowed all workers earning above the ceiling to obtain membership on a voluntary basis during a 3-month open season. Since that time, persons entering the work force with earnings above the ceiling have been allowed a similar 3-month grace period to join the public system on a voluntary basis.

### BENEFITS

Federal law requires all sick funds to cover the following items without patient cost-sharing, except as noted:

Physicians' services, in home, office, or elsewhere.

Prescription drugs, subject to 20 percent coinsurance up to a maximum of DM 2.50; pensioners, persons on cash assistance, and partially employed persons are exempt from such cost-sharing.

Hospitalization up to a maximum of 78 weeks per illness over a 3-year period; includes medical and related treatment, room and board in ward or semiprivate accommodations, nursing services, drugs, use of medical aids and apparatus, etc.

Prenatal care, delivery, and cash benefits for the period of maternity nursing.

Screening for prostatic, rectal, and cervical cancer, as well as a number of infant diseases.

Routine dental care, with partial payment for orthodontics and dental prostheses; treatment is covered only when provided by authorized insurance fund dental surgeons on basis of a special certificate presented by the patient; for dentures and other prosthetic devices, patient generally pays at least one-third of the cost.

Prosthetic equipment, e.g. eyeglasses, trusses, artificial limbs, orthopedic shoes; for minor medical appliances, 20 percent of the charges are paid by the patient; for major appliances the patient is generally required to pay one-third of the cost.

Home care when used as a substitute for hospitalization.

Cash payment in the event of death.

Cash sickness allowance fixed by law, payable after the employer has paid the full wage or salary for 6 weeks from the beginning of a disability; amounts range from 75 percent of the customary wage for persons without dependents to 85 percent of the customary wage for persons with dependents, for up to 78 weeks in a 3-year period.

The insured persons have free choice of so-called insurance fund doctor (defined later in this section). Upon receipt of services from a physician, the patient must present the doctor with a "sick certificate," which acts as proof of membership in an insurance fund and also serves as the basis for payment for services received. Sick certificates are issued free of charge to each person once every calendar quarter and entitle the patient to unlimited physician visits within that quarter.

For the physician, sick certificates act as a money substitute; the doctor turns in the sick certificates to the Insurance Fund Doctor's Association for cash reimbursement of the services he has rendered to the insured patient.

Beginning in 1970, insured persons who did not use their sick certificates were repaid up to DM 30 per year, or DM 10 for as many as three of the four books of certificates each insured person is entitled to receive each year. As a utilization control, redemption of unused sick certificates for cash proved to be of questionable merit:

> Some doctors believe that this measure may inhibit patients from seeking medical advice although they are in need of it. Others believe that the amount of DM 10 is too low to serve as an incentive to pay for services privately.[3]

This "no claim" bonus system cost the insurance funds more than DM 300 million in the first year of its operation, without providing any offset savings; on October 1, 1973, the scheme was abolished.

Only a few funds pay for convalescent home treatment and home nursing care on a standard basis, but treatment provided at West German health spas is part of standard coverage.

## Financing

Health insurance is financed primarily by equal contributions from employers and employees. For very low wage earners the employer pays the full contribution. Each insurance fund fixes its contribution rates for members according to its own needs. In general, however, the range is between 4 and 5.5 percent of insurable earnings up to DM 22,500 per year on both the worker and employer. The ceiling placed on wages is automatically adjusted on an annual basis, in accordance with a formula taking into account changes in national wage levels.

Contributions on behalf of compulsorily insured pensioners (all persons employed for remuneration are compulsorily insurable for pension insurance without regard to the nature of work or amount of their income) are paid by the social insurance pension funds. Voluntarily insured pensioners (persons whose employment was exempted from compulsory pension insurance—for example, part-time or intermittent workers, government employees, workers not previously insurable due to the pre-1967 wage ceiling, etc.) make direct contributions which are refunded by the pension funds. The Federal Institute for Labor makes contributions for persons receiving unemployment compensation and maintenance allowances.

The amount an individual pays to his sick fund is related only to the amount of his wages and is independent of the medical or social risks he may present to the fund. In addition, the amount of the wage earner's contribution to the fund is also unrelated to whether he is an individual enrollee or whether he has dependents who are also legally eligible to receive medical services through the fund.

Until January 1971, employers had been required to make health insurance contributions only for those employees who were compulsorily insured (all blue-collar workers and those white-collar workers with earnings below the ceiling). Thus, for white-collar workers whose earnings were above the ceiling, employer participation in health insurance contributions was entirely voluntary. Since 1971, however, employers must make a payment for all insured workers regardless of how high the earnings. If an employee does not join the public system, he can apply his employer's contribution toward private health insurance premiums. For high-income white-collar workers, the employer's contribution equals the maximum he would have to pay if their earnings were at the ceiling.[4]

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[3] M. Pflanz, "German Health Insurance: The Evolution and Current Problems of the Pioneer System." International Journal of Health Services, Nov. 1971: 319.

Government subsidies play only a small role in financing the public health insurance system and are mainly for refunds to the sickness funds of DM 400 for every cash maternity allowance payment. Sizable government contributions to the health care delivery system are, however, provided through payments to the hospitals and for public health programs. Government expenditures account for about one-fourth of total national health care costs, with public insurance expenditures accounting for about three-fifths.

## ADMINISTRATION

More than 1,800 semiautonomous health insurance funds and mutual benefit insurance funds administer the program, under the general supervision of the Ministry of Health. Each fund is financially and organizationally autonomous and responsible for balancing its own income and expenditures. They are organized as follows:

> A total of 401 local health insurance funds (general scheme funds), 107 land health insurance funds for agriculture, 1,133 works health insurance funds operating in the larger enterprises, 178 trade association health insurance funds for small-scale artisan firms, 1 seaman's health insurance fund for seagoing employment, the miners' special scheme, 7 mutual benefit funds for nonmanual workers, 8 mutual benefit funds for manual workers. At the beginning of 1970, the insurance funds employed about 77,000 persons.
>
> The insurance funds are self-governing bodies * * * with an executive committee and a delegates' assembly, comprised of equal numbers of representatives of workers and employers. Exceptions are the organs of the mutual benefit funds, which are comprised solely of representatives of the insured persons, and the organs of the miners' special scheme fund, which are comprised of two-thirds of workers' representatives, and one-third of employers' representatives. The delegates' assembly resolves on the statutes of the funds, in which contribution rates and additional benefits are laid down.
>
> For the purpose of safeguarding supralocal and common interest, the insurance funds are organized in insurance fund associations:
>
> Federal Association of Local Health Insurance Funds in Bad Godesberg.
> Federal Association of Land Insurance Funds in Hannover.
> Federal Association of Works Health Insurance Funds in Essen.
> Federal Association of Trade Association Health Insurance Funds in Cologne.
> Association of Manual Workers Mutual Benefit Funds in Hamburg.
> Association of Nonmanual Health Funds in Hamburg.
> Miner's Special Scheme in Bochum.
> Working Community for Common Problems of Health Insurance in Frankfort.
> Federal Association of Insurance Fund Doctors in Cologne.
> Federal Association of Insurance Dental Surgeons in Cologne.[5]

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[4] Joseph G. Simanis, "Health Insurance Legislation in West Germany." Social Security Bulletin, June 1971: 20–21.

[5] Taken from "Survey of Social Security in the Federal Republic of Germany," p. 144.

The government establishes broad legislative guidelines with respect to the operation of the insurance system. Contract and payment agreements and benefit packages of the various sick funds may not violate those guidelines. However, in all other matters, the government may not interfere in the negotiated decisions of the sick funds and the associations of insurance doctors, since the funds are legally autonomous bodies and are not government agents or subdivisions.

As self-governing, autonomous organizations, the sick funds are subject to direct governmental supervision only in cases of violation of the law. They are administered by an executive committee composed of an equal number of representatives of the insured members and of their employers.

For blue-collar workers, membership in a particular sick fund is generally determined by the locality of type of firm by which the individual is employed. White-collar workers, on the other hand, have been allowed to join so-called substitute funds (Ersatzkassen) in lieu of those funds they would have had to join if they were grouped together with blue-collar workers according to place of work. Traditionally, about 85 percent of eligible white-collar workers have belonged to substitute funds, which have frequently offered more generous benefits because of higher contribution rates on the higher salaries of their white-collar members.

Since the capacity of funds is influenced considerably by the number of members and their financial contributions, insurance funds are in mutual competition to enlarge their membership. Questions have been raised about the relative advantages of a multiplicity of sick funds in competition with one another:

> With respect to this, there are, of course, endeavors toward a centralized and unified insurance system. This may possibly be contrary to the interest of the insured, who receive more individual protection under present conditions. Certainly it is not favored by many of the sick funds officials, who may presently pursue their particular interest and initiatives; and such a centralization would not be viewed favorably by the doctors, since the multiplicity of funds allows a certain latitude in negotiating on fees.
>
> There must be raised, however, the questions of whether a relative unification (if not a total centralization) of the dispersed parts of the system of funds should be realized * * * in order to achieve a better balance of risks connected with very expensive treatment, and in order to rationalize by computer the many administrative processes. Until now, computers are used by many funds only for keeping books on contributions and for calculating fee-for-service rates. Most of the funds and the associations of insurance doctors have only small computers. Moreover, data are not related to the individual rendered service, but only to the worker primarily insured, with the exclusion of his dependents. For this reason, a genuine calculation of risk, within defined categories of the population, is as difficult as a continuous control of efficiency. Better electronic data processing will be possible, however, when a unified system of identify numbers is introduced, which is planned for 1973.[6]

## REIMBURSEMENT METHODS

Hospitals in West Germany are predominantly public or voluntary (charity) institutions. Proprietary hospitals are few and play little part in providing medical care to publicly insured patients. Within limits set by the Federal Government, hospitals negotiate with the sick funds a prospective per diem rate for hospitalization. Sick fund payments do not, however, cover the real costs of hospital care. Community tax income and charitable contributions subsidize the nonreimbursed costs of care. The average per diem rate paid by sick funds in 1970 for hospital care was DM 40.

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[6] Pflanz, p. 321.

Hospital physicians (about a third of the country's qualified physicians) are generally salaried employees and, as such, do not qualify for fee-for-service reimbursement by the sick funds. Their services are included in the hospital's bill.

West Germany currently has about 11 hospital beds per 1,000 population. Comparative international statistics for 1969 showed that West Germany had a higher rate of hospital admissions per inhabitant (143 per 1,000 inhabitants) than any other country in the Western World. The average length of stay in an acute care hospital in 1969 was 18.6 days, more than double the 1969 rate of 8.5 days for the United States. Because the official per diem hospital rate approved by the government for reimbursement by sick funds is considered inadequate to cover real costs, it has been suggested that hospitals in West Germany attempt to solve this problem by keeping patients longer than necessary:

> To one outside the medical fraternity, this might not make sense, but it does because a hospital loses money during the initial days of a patient's stay when costly tests and procedures are being done and makes money later on when the patient is virtually nothing more than a hotel guest * * *.
>
> Another shortcoming is the peculiar prohibition that tradition and nonhospital doctors have forced onto the system, preventing hospitals from having outpatient clinics. (The only exceptions are the teaching hospitals that may have clinics for educational purposes.) As a result of this ban, patients who require more care than a nonhospital physician can provide must be hospitalized in costly facilities even though they could be treated on a more economical outpatient basis.[7]

For physicians, reimbursement is based on the number of sick certificates (or krankenschein) received from insured patients each quarter and forwarded to an association of insurance doctors for reimbursement. Individual services rendered to each patient are recorded on the certificate and the doctor receives points for each task. The average number of points, or services rendered, is calculated for all doctors at the end of each quarter. If the physician's average number of services is at or below the national average for all doctors, he receives full payment, but if his average is above this, he may receive a cutback.

Fee schedules are determined by a commission representing the doctors, sickness insurance funds, government, and other interested parties. The schedules include over 1,500 different procedures, ranging from such items as the amount a doctor can charge for mileage on a house call to the cost of an injection. Doctors are permitted to charge private patients higher fees than those set forth in the negotiated fee schedules for publicly insured patients. Although private patients compose only 12 percent of all patients, about 20 percent of the physician's average office income comes from the treatment of such patients.

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[7] Donald Drake, "Health Care—The European Way: Germany Uses Dual System." Philadelphia Inquirer, Dec. 19, 1969. Reprinted in the Congressional Record, Dec. 19, 1969; S17340.

In 1973, West Germany had more than 100,000 doctors (a physician-per-population ratio of 1 per 600, one of the most favorable in the world). About 55 percent of qualified physicians are engaged in independent practice, about one-third employed in hospitals, and about one-tenth involved in administration or research activities. Almost all physicians engaged in independent practice participate in the public health insurance scheme as "insurance doctors." Insurance doctors are organized in regional associations, which are self-governing and headed by elected physician members. It is the association, not the individual doctor, which negotiates fee-for-service contracts with particular sick funds. The association then distributes sick-fund contributions in proportion to the services rendered by each member physician. Treatment provided by dentists is remunerated on generally the same basis as that for physicians.

Review of physicians' services provided to insured sick-fund members is utilized primarily as an economic control, rather than a control over the quality of care:

> Although they would be authorized by legislation, there are no quality controls, while economical behavior of doctors is relatively often submitted to scrutiny. The initative for scrutiny may be taken by the sick fund or by the association of insurance doctors. But in any case, disciplining a doctor is a matter for doctors who are elected members of a committee of the association of insurance doctors. * * *
>
> * * * The average, to which every control is oriented, is calculated from the sum of costs referrable to the different specialty groups of doctors (including, of course, general practitioners). There are two categories of doctors who are responsible for lowering this crucial average and so, in fact, handicap their colleagues who order more expensive therapeutic prescriptions: (a) older doctors who fall behind in acquiring new knowledge and thereby do not participate in medical progress which necessarily requires more expensive measures; (b) doctors who to a large extent get free specimens from pharmaceutical firms in order to distribute them to their patients.[8]

## HEALTH EXPENDITURES

In 1969, West Germany expended 5.7 percent of its gross national product on health care. Between 1961 and 1969, health expenditures rose at an average annual rate of 10.3 percent. During this period, the average annual rate of growth in the Consumer Price Index was 2.6 percent; the average annual rate of increase in health expenditures, adjusted by the average of the CPI and wage index changes, registered 4.7 percent. Government health expenditures, as a percent of the total government budget, reflected a decrease in 1969 to 3.5 percent, down from 3.7 percent in the previous year.[9]

It has been reported that the financial situation of the public health insurance scheme has tended to deteriorate in recent years. Until 1967, insurance fund income exceeded expenditure, but beginning in 1968, annual expenditure has exceeded income by about 1 percent. This ratio of income-to-expenditure has apparently been stabilized, with estimated health insurance fund expenditures for 1973 exceeding income by DM 305 million, or slightly less than 1 percent of total income.

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[8] Pflanz, p. 320.

[9] Joseph G. Simanis, "Medical Care Expenditures in Seven Countries." Social Security Bulletin, March 1973: 39–42.

# PART IV

# Existing Health Programs Under Jurisdiction of Committee on Ways and Means

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## Chapter 1. Medicare (Title XVIII of the Social Security Act)

### BACKGROUND

Medicare legislation had been considered for many years before its enactment in 1965. Bills to provide hospital insurance and related health benefits as part of the national social insurance system were first introduced in the Congress as early as 1952 and received active consideration beginning in 1958. The program which finally evolved—including major amendments in 1968 and 1972—represents almost a quarter century distillation of differing and conflicting views of many people and organizations.

Medicare is a federally administered program providing hospital and medical insurance protection for almost 24 million people—those 65 and older, people under age 65 who have been receiving cash benefits under the social security or railroad retirement programs for 2 years because they are disabled, and certain chronic kidney disease patients under 65.

The medicare program is under the overall direction of the Secretary of Health, Education, and Welfare. Within the Department, the Bureau of Health Insurance of the Social Security Administration is responsible for policy and administrative control of the program, with much of the day-to-day operational work of the program performed under contract by some 130 commercial insurance companies and Blue Cross-Blue Shield plans. These organizations have the responsibility for reviewing claims for benefits and making payments. In fiscal year 1975, these organizations processed 27 million bills from hospitals and other participating facilities and 81 million bills for physicians' and other medical services.

Over $14 billion in medicare benefits were paid in fiscal year 1975, approximately 13 percent of the Nation's total health care bill. In each State, health officials assist the Federal Government in determining whether facilities that wish to provide services to medicare beneficiaries meet the conditions for participation in the medicare program. These conditions relate to the quality of patient care and various health and safety requirements. There are about 16,000 health care facilities—hospitals, skilled nursing facilities, home health agencies, and independent laboratories participating in medicare.

## Description of Program

The medicare program consists of two parts—the hospital insurance plan (part A) and the supplementary medical insurance plan (part B). Hospital insurance benefits include: (*a*) inpatient hospital services for up to 90 days in a benefit period, plus a lifetime reserve of 60 additional days of hospital care after the 90 days have been exhausted; (*b*) posthospital extended care in a skilled nursing facility for up to 100 days in a benefit period; and (*c*) posthospital home health services for as many as 100 home health visits. A benefit period begins with the first day an individual is furnished inpatient hospital or skilled nursing facility services, and does not end until he has not been an inpatient in either a hospital or a skilled nursing facility for 60 consecutive days.

Supplementary medicare insurance benefits (part B) include: (*a*) physicians' and surgeons' services, certain nonroutine services of podiatrists, limited services provided by chiropractors, and the services of independently practicing physical therapists; (*b*) certain other medical and health services such as diagnostic services, diagnostic X-ray tests, laboratory tests and other diagnostic services, X-ray, radium and radioactive isotope therapy, ambulance services, and additional medical supplies, appliances, equipment, and prostheses; (*c*) outpatient hospital services; (*d*) home health services (with no requirement of prior hospitalization) for 100 visits during a calendar year; and (*e*) outpatient physical and speech therapy services furnished by approved providers.

Both the hospital insurance and medical insurance plans contain limitations on program benefits in the form of deductible and coinsurance amounts for which the beneficiary is responsible. The most important of these are a variable deductible—now $104—with respect to part A hospital services and a $60 deductible and 20-percent coinsurance amount with respect to most part B services.[1]

Hospital insurance (part A) coverage is available to: (*a*) all people 65 and over who are entitled to receive social security cash benefits or railroad retirement benefits; (*b*) social security beneficiaries under age 65 who have been entitled to social security or railroad retirement benefits for at least 24 consecutive months on the basis of a disability; (*c*) otherwise ineligible persons, 65 and older, who elect to enroll in the hospital insurance program and to pay the full cost of their coverage, $45 a month now, increasing in the future as costs increase; (*d*) almost all people under 65 who suffer from chronic kidney disease; and (*e*) those who were 65 or nearly that age when the program was enacted in 1965 but who were not eligible for cash benefits.

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[1] The current monthly premium (paid by people enrolled in the medical insurance part of the program) is also sometimes thought of as a form of cost sharing. The medical insurance premium is discussed later in this chapter.

Supplementary medical insurance is available to all hospital insurance beneficiaries and to all other people 65 and over, except recent immigrants.

Payment of medicare benefits is on the basis of (1) reasonable cost in the case of hospitals and other institutional providers and (2) reasonable charges in the case of physicians and other noninstitutional suppliers of services.

Reasonable costs are determined on the basis of actual costs incurred by the individual provider in furnishing covered services to beneficiaries. The principles of reimbursement provide that all necessary and proper costs which maintain the operation of patient care facilities and activities will be included in the computation of medicare reimbursement. A provision in the Social Security Amendments of 1972 now permits establishment of upper limits of "reasonableness" of costs by hospital category or type of service.

The determination of the reasonableness of charges is made by carriers (private organizations with which the Secretary has contracted for the payment of benefits) pursuant to policy guidelines issued by the Social Security Administration, which are established within the framework of general statutory instructions. In determining reasonable charges, the carrier must take into consideration the customary charges for similar services by the physician or other person furnishing the services, as well as the prevailing charges in the locality for similar services. The prevailing charge for a service is limited to the 75th percentile of the customary charges in an area. The 75th percentile amount is increased over time by a factor which takes into account increased costs of practice and increases in earnings levels in the area.

The hospital insurance part of the program is financed primarily through social security payroll contributions paid by employees, employers, and self-employed people covered under social security. The contribution rates are the same for self-employed persons, employees, and employers, and are paid on annual earnings up to the same limit that applies to contributions for the cash benefit program—$15,300 in 1976. Hospital insurance benefits for the present aged who qualify on the basis of the special transitional insured status provision are financed from general revenues. Hospital insurance benefits for aged persons not otherwise eligible are financed through monthly premiums (currently $45) paid by those who voluntarily enroll in the hospital insurance program.

The supplementary medical insurance (SMI) part of the program, in which participation is voluntary, is financed from premiums paid by aged, disabled, and chronic renal disease enrollees and from Federal funds. Under the law the Secretary of Health, Education, and Welfare is required to review the premium rate and to promulgate in December of each year the rate to be in effect for the following fiscal year. Increases in the rate are to be directly related to the expected increase in program costs, but cannot be increased in the future by a proportion higher than the proportionate increase of cash social security benefits resulting from a general benefit increase. The current premium rate is $7.20.

Of the some 23 million people age 65 and older in the United States, 22.3 million—about 95 percent—had hospital insurance protection on January 1, 1975. About 21.6 million aged people were enrolled in the voluntary supplementary medical insurance plan. On January 1, 1975, 2.0 million disability beneficiaries were enrolled in the hospital insurance program and 1.9 million were enrolled in the supplementary medical insurance program. Eleven thousand other persons were enrolled in the medicare program because they were suffering from chronic kidney disease.

## ADMINISTRATION

Under the hospital insurance part of the program, groups or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if approved by the Secretary and agreeable to the intermediary selected. In addition, a provider may deal directly with the Social Security Administration.

The Secretary may enter into an agreement with a nominated organization if he finds this to be consistent with effective and efficient administration of the hospital insurance program. The intermediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for (1) furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services, (2) serving as a center for communicating with providers, and (3) making audits of provider records. Hospital insurance intermediaries also make payments for home health and outpatient hospital services covered under medical insurance.

Requests for medicare payment for covered services generally are submitted by the provider of services; they must be signed by the beneficiary (or someone for him, if he is unable to do so). The provider is reimbursed on the basis of reasonable costs of covered services and bills the beneficiary for deductible and coinsurance amounts as well as for services not covered by the program.

In some instances, hospitals may bill the program for physician services rendered to inpatients. In these cases, payment is made by the hospital insurance intermediary. Depending on the nature of the billing, funds are transferred from the supplementary medical insurance trust fund to the hospital insurance trust fund to cover the cost of these services, or are paid directly from the supplementary medical insurance trust fund.

The intermediary selected by the provider reviews claims for payment and pays the provider. Actual payment is made on the basis of an interim rate established between the provider and the intermediary. Final settlement for each provider's operating year is made on the basis of a cost report submitted by the provider, and subject to an independent audit.

No payments can be made to Federal facilities except for emergency services, unless the provider serves as a community institution. In addition, payment cannot be made to a provider for those services it is obligated to render at public expense under Federal law or contract.

Under the medical insurance program, the Secretary of Health, Education, and Welfare may enter into contracts with carriers for the performance of specified administrative functions. The carriers' principal function is to determine whether charges are allowable (reasonable) and to make payment. Carriers also have the authority and responsibility to determine, in a given case, whether a claim is for a covered service and to deny claims for noncovered or excluded items or services. In addition, carriers are to assist in the application of safeguards against unnecessary utilization of services.

The law requires that in determining allowed (reasonable) charges, carriers should take into account the customary charges of physicians and other suppliers of medical services and the prevailing charges in the locality for similar services. The law also specifies that the allowed (reasonable) charge for a service may not exceed the charge applicable for a similar service and under comparable circumstances to the carrier's own policyholders and subscribers. The allowed charge, therefore, is a charge for a service which in the absence of unusual circumstances or medical complications is the lowest of the following: (1) the actual charge of the physician or other person rendering the service, (2) the charge the physician or other person customarily makes for similar services, or (3) the prevailing charges in the locality for similar services.

Claims for payment of supplementary medical insurance benefits may be submitted to the carrier either by the patient or by the physician or other supplier of services. If the patient submits a claim (an itemized bill) directly to the carrier, he receives direct payment of benefits for covered services: he remains responsible for the physician's (or supplier's) bill. The patient may assign the benefits to a physician or other supplier of services willing to accept assignment. In this case, the physician (or supplier) agrees that the allowed or reasonable charge determined by the carrier is the total charge. The physician (or supplier) submits the bill and is reimbursed. In this situation, the patient remains responsible for the remaining 20 percent of the allowed charges for covered services and the $60 deductible (if applicable to the current bill).

Table 1.—*National data on the medicare program* [1]

| Item | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 |
|---|---|---|---|---|---|---|---|---|
| Persons enrolled as of Jan. 1 for: | | | | | | | | |
| Hospital insurance (HI) | 19, 465, 411 | 19, 750, 572 | 20, 173, 819 | 20, 588, 456 | 20, 966, 267 | 21, 374, 693 | [2] 23, 924, 000 | 24, 311, 731 |
| Supplementary medical insurance (SMI) | 18, 021, 125 | 18, 854, 607 | 19, 329, 363 | 19, 738, 504 | 20, 145, 286 | 20, 544, 688 | [2] 23, 167, 000 | 23, 503, 227 |
| HI and/or SMI | 19, 495, 512 | 19, 815, 300 | 20, 278, 398 | 20, 732, 693 | 21, 154, 498 | 21, 601, 315 | [2] 24, 201, 000 | 22, 549, 181 |
| Amounts reimbursed during the fiscal year: | | | | | | | | |
| HI: Total (in thousands) | $3, 736, 322 | $4, 654, 000 | $4, 804, 243 | $5, 442, 971 | $6, 109, 139 | $6, 749, 000 | [3] $8, 118, 439 | |
| SMI: Total (in thousands) | $1, 389, 622 | $1, 644, 842 | $1, 979, 288 | $2, 034, 999 | $2, 255, 069 | $2, 439, 500 | [3] $3, 119, 598 | |
| HI: Amount per HI enrollee | $192 | $236 | $240 | $264 | $291 | $316 | [3] $339 | |
| SMI: Amount per SMI enrollee | $77 | $87 | $103 | $103 | $112 | $119 | [3] $135 | |
| Participating facilities as of July: | | | | | | | | |
| Number: | | | | | | | | |
| All hospitals | 6, 865 | 6, 825 | 6, 776 | 6, 745 | 6, 726 | 6, 757 | 6, 773 | 6, 773 |
| Short-stay | 6, 221 | 6, 182 | 6, 153 | 6, 153 | 6, 131 | 6, 132 | 6, 102 | 6, 107 |
| Tuberculosis | 118 | 113 | 105 | 95 | 80 | 65 | 56 | 43 |
| Psychiatric | 341 | 344 | 341 | 335 | 346 | 352 | 357 | 385 |
| Other long-stay | 185 | 186 | 177 | 162 | 169 | 208 | 218 | 238 |
| Skilled nursing facilities | | 4, 849 | 4, 656 | 4, 287 | 4, 041 | 3, 977 | 3, 952 | 3, 932 |
| Beds: | | | | | | | | |
| All hospitals | 1, 164, 931 | 1, 176, 656 | 1, 199, 030 | 1, 188, 013 | 1, 155, 982 | 1, 148, 428 | 1, 143, 664 | 1, 140, 395 |
| Short-stay | 781, 990 | 798, 652 | 815, 244 | 834, 514 | 850, 070 | 864, 786 | 882, 496 | 901, 787 |
| Tuberculosis | 23, 903 | 23, 263 | 21, 712 | 18, 995 | 15, 065 | 13, 048 | 11, 303 | 6, 823 |
| Psychiatric | 318, 896 | 313, 519 | 320, 709 | 300, 696 | 259, 329 | 236, 550 | 215, 513 | 198, 802 |
| Other long-stay | 40, 142 | 41, 222 | 41, 365 | 33, 808 | 31, 518 | 34, 044 | 34, 352 | 33, 013 |
| Skilled nursing facilities | | 341, 735 | 333, 630 | 307, 548 | 291, 636 | 287, 606 | 294, 000 | 287, 479 |
| Beds per 1,000 HI enrollees: | | | | | | | | |
| Short-stay hospitals | 40. 1 | 40. 4 | 40. 4 | 40. 5 | 40. 5 | 41. 6 | 41. 7 | 41. 7 |
| Skilled nursing facilities | | 17. 3 | 16. 7 | 13. 9 | 13. 9 | 13. 8 | 13. 9 | 13. 3 |
| Home health agencies | 2, 093 | 2, 209 | 2, 350 | 2, 284 | 2, 222 | 2, 211 | 2, 248 | 2, 242 |
| Independent laboratories | 2, 566 | 2, 670 | 2, 684 | 2, 751 | 2, 873 | 2, 929 | 3, 029 | 3, 048 |

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[1] Includes United States and all outlying areas.

[2] Persons enrolled as of July 1, 1974.

[3] Amounts reimbursed during the calendar year 1974.

Source: Social Security Administration.

## TABLE 2.—*State data on the medicare program*

### ALABAMA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 411, 539 |
| Supplementary medical insurance (SMI) | 406, 867 |
| HI and/or SMI | 373, 994 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $98, 792, 650 |
| SMI: Total | $40, 102, 690 |
| HI: Amount per HI enrollee | $245 |
| SMI: Amount per SMI enrollee | $101 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 136 |
| Short-stay | 131 |
| Tuberculosis | 2 |
| Psychiatric | 3 |
| Other long-stay | 0 |
| Skilled nursing facilities | 89 |
| Beds: | |
| All hospitals | 17, 954 |
| Short-stay | 17, 439 |
| Tuberculosis | 317 |
| Psychiatric | 198 |
| Other long-stay | 0 |
| Skilled nursing facilities | 5, 372 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 49. 2 |
| Skilled nursing facilities | 15. 1 |
| Home health agencies | 70 |
| Independent laboratories | 18 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 129. 3 |
| Skilled nursing facilities admissions | 6. 3 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 360. 2 |
| Skilled nursing facilities admissions | 17. 5 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 18. 1 |
| Skilled nursing facility admissions | 0. 2 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 410. 3 |
| Skilled nursing facility admissions | 4. 4 |

### ALASKA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 9, 127 |
| Supplementary medical insurance (SMI) | 7, 573 |
| HI and/or SMI | 8, 148 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $3, 069, 765 |
| SMI: Total | $1, 416, 915 |
| HI: Amount per HI enrollee | $350 |
| SMI: Amount per SMI enrollee | $194 |

Footnotes at end of table, p. 451.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 22 |
| Short-stay | 21 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 0 |
| Skilled nursing facilities | 4 |
| Beds: | |
| All hospitals | 1, 033 |
| Short-stay | 833 |
| Tuberculosis | 0 |
| Psychiatric | 200 |
| Other long-stay | 0 |
| Skilled nursing facilities | 166 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 108. 1 |
| Skilled nursing facilities | 21. 5 |
| Home health agencies | 1 |
| Independent laboratories | 2 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 2. 3 |
| Skilled nursing facilities admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 295. 9 |
| Skilled nursing facilities admissions | 17. 9 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 0. 3 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 340 |
| Skilled nursing facility admissions | 16. 8 |

ARIZONA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 227, 273 |
| Supplementary medical insurance (SMI) | 220, 597 |
| HI and/or SMI | 209, 798 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $67, 838, 345 |
| SMI: Total | $36, 173, 773 |
| HI: Amount per HI enrollee | $305 |
| SMI: Amount per SMI enrollee | $167 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 62 |
| Short-stay | 59 |
| Tuberculosis | 0 |
| Psychiatric | 3 |
| Other long-stay | 0 |
| Skilled nursing facilities | 19 |
| Beds: | |
| All hospitals | 8, 839 |
| Short-stay | 7, 759 |
| Tuberculosis | 0 |
| Psychiatric | 1, 080 |
| Other long-stay | 0 |
| Skilled nursing facilities | 1, 000 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 39. 6 |
| Skilled nursing facilities | 5. 1 |
| Home health agencies | 11 |
| Independent laboratories | 48 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 65. 9 |
| Skilled nursing facilities admissions | 3. 4 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 323. 1 |
| Skilled nursing facilities admissions | 16. 5 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 7. 3 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 395. 5 |
| Skilled nursing facility admissions | 4. 9 |

ARKANSAS

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 295, 486 |
| Supplementary medical insurance (SMI) | 290, 324 |
| HI and/or SMI | 268, 323 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $62, 833, 040 |
| SMI: Total | $29, 173, 405 |
| HI: Amount per HI enrollee | $217 |
| SMI: Amount per SMI enrollee | $102 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 96 |
| Short-stay | 92 |
| Tuberculosis | 0 |
| Psychiatric | 3 |
| Other long-stay | 1 |
| Skilled nursing facilities | 10 |
| Beds: | |
| All hospitals | 10, 371 |
| Short-stay | 9, 065 |
| Tuberculosis | 0 |
| Psychiatric | 1, 236 |
| Other long-stay | 70 |
| Skilled nursing facilities | 557 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 35. 2 |
| Skilled nursing facilities | 2. 2 |
| Home health agencies | 78 |
| Independent laboratories | 11 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 106. 2 |
| Skilled nursing facilities admissions | . 7 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 408. 8 |
| Skilled nursing facilities admissions | 2. 8 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 12. 3 |
| Skilled nursing facility admissions | (3) |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 407. 3 |
| Skilled nursing facility admissions | . 9 |

### CALIFORNIA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 2, 182, 054 |
| Supplementary medical insurance (SMI) | 2, 153, 346 |
| HI and/or SMI | 2, 017, 083 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $885, 021, 114 |
| SMI: Total | $431, 328, 269 |
| HI: Amount per HI enrollee | $413 |
| SMI: Amount per SMI enrollee | $204 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 595 |
| Short-stay | 544 |
| Tuberculosis | 2 |
| Psychiatric | 38 |
| Other long-stay | 11 |
| Skilled nursing facilities | 933 |
| Beds: | |
| All hospitals | 94, 272 |
| Short-stay | 78, 815 |
| Tuberculosis | 274 |
| Psychiatric | 10, 554 |
| Other long-stay | 4, 629 |
| Skilled nursing facilities | 78, 895 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 40. 7 |
| Skilled nursing facilities | 40. 8 |
| Home health agencies | 88 |
| Independent laboratories | 754 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 615 |
| Skilled nursing facilities admissions | 103. 1 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 314 |
| Skilled nursing facilities admissions | 52. 6 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 73. 7 |
| Skilled nursing facility admissions | 3. 7 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 399. 6 |
| Skilled nursing facility admissions | 20. 1 |

### COLORADO

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 222, 951 |
| Supplementary medical insurance (SMI) | 217, 841 |
| HI and/or SMI | 210, 352 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $73, 162, 830 |
| SMI: Total | $29, 292, 943 |
| HI: Amount per HI enrollee | $335 |
| SMI: Amount per SMI enrollee | $137 |

Footnotes at end of table.

### TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 88 |
| Short-stay | 79 |
| Tuberculosis | 0 |
| Psychiatric | 4 |
| Other long-stay | 5 |
| Skilled nursing facilities | 62 |
| Beds: | |
| All hospitals | 11, 780 |
| Short-stay | 9, 889 |
| Tuberculosis | 0 |
| Psychiatric | 1, 559 |
| Other long-stay | 332 |
| Skilled nursing facilities | 3, 772 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 48. 9 |
| Skilled nursing facilities | 19. 7 |
| Home health agencies | 29 |
| Independent laboratories | 39 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 79. 4 |
| Skilled nursing facilities admissions | 4. 8 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 389. 6 |
| Skilled nursing facilities admissions | 23. 8 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 6. 9 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 468. 8 |
| Skilled nursing facility admissions | 7. 7 |

#### CONNECTICUT

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 337, 387 |
| Supplementary medical insurance (SMI) | 331, 134 |
| HI and/or SMI | 317, 451 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $138, 361, 662 |
| SMI: Total | $53, 499, 195 |
| HI: Amount per HI enrollee | $418 |
| SMI: Amount per SMI enrollee | $164 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 52 |
| Short-stay | 35 |
| Tuberculosis | 0 |
| Psychiatric | 9 |
| Other long-stay | 8 |
| Skilled nursing facilities | 130 |
| Beds: | |
| All hospitals | 15, 928 |
| Short-stay | 9, 885 |
| Tuberculosis | 0 |
| Psychiatric | 4, 653 |
| Other long-stay | 1, 390 |
| Skilled nursing facilities | 11, 680 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 32. 1 |
| Skilled nursing facilities | 37. 9 |
| Home health agencies | 87 |
| Independent laboratories | 58 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 86 |
| Skilled nursing facilities admissions | 12. 6 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 277. 2 |
| Skilled nursing facilities admissions | 40. 5 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 7. 7 |
| Skilled nursing facility admissions | 0. 4 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 366 |
| Skilled nursing facility admissions | 18. 6 |

DELAWARE

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 54, 855 |
| Supplementary medical insurance (SMI) | 53, 349 |
| HI and/or SMI | 50, 488 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $19, 213, 486 |
| SMI: Total | $6, 492, 689 |
| HI: Amount per HI enrollee | $357 |
| SMI: Amount per SMI enrollee | $124 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 10 |
| Short-stay | 7 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 2 |
| Skilled nursing facilities | 11 |
| Beds: | |
| All hospitals | 2, 792 |
| Short-stay | 1, 718 |
| Tuberculosis | 0 |
| Psychiatric | 922 |
| Other long-stay | 152 |
| Skilled nursing facilities | 632 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 35. 0 |
| Skilled nursing facilities | 12. 9 |
| Home health agencies | 6 |
| Independent laboratories | 10 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 13. 1 |
| Skilled nursing facilities admissions | 0. 7 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 265. 5 |
| Skilled nursing facilities admissions | 13. 6 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 1. 5 |
| Skilled nursing facility admissions | ([3]) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 348. 7 |
| Skilled nursing facility admissions | 4. 3 |

### FLORIDA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 1, 272, 322 |
| Supplementary medical insurance (SMI) | 1, 266, 325 |
| HI and/or SMI | 1, 214, 445 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $402, 228, 809 |
| SMI: Total | $214, 051, 197 |
| HI: Amount per HI enrollee | $319 |
| SMI: Amount per SMI enrollee | $171 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 217 |
| Short-stay | 202 |
| Tuberculosis | 1 |
| Psychiatric | 14 |
| Other long-stay | 0 |
| Skilled nursing facilities | 146 |
| Beds: | |
| All hospitals | 47, 423 |
| Short-stay | 39, 421 |
| Tuberculosis | 450 |
| Psychiatric | 7, 552 |
| Other long-stay | 0 |
| Skilled nursing facilities | 9, 185 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 34. 9 |
| Skilled nursing facilities | 8. 1 |
| Home health agencies | 42 |
| Independent laboratories | 123 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 379. 6 |
| Skilled nursing facilities admissions | 23. 1 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 322. 0 |
| Skilled nursing facilities admissions | 23. 1 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 32. 7 |
| Skilled nursing facility admissions | . 5 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 406. 4 |
| Skilled nursing facility admissions | 6. 3 |

### GEORGIA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 470, 757 |
| Supplementary medical insurance (SMI) | 463, 695 |
| HI and/or SMI | 423, 024 |

Footnotes at end of table.

## TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $124, 851, 134 |
| SMI: Total | $46, 221, 845 |
| HI: Amount per HI enrollee | $271 |
| SMI: Amount per SMI enrollee | $102 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 181 |
| Short-stay | 167 |
| Tuberculosis | 1 |
| Psychiatric | 10 |
| Other long-stay | 3 |
| Skilled nursing facilities | 47 |
| Beds: | |
| All hospitals | 22, 236 |
| Short-stay | 20, 722 |
| Tuberculosis | 317 |
| Psychiatric | 928 |
| Other long-stay | 269 |
| Skilled nursing facilities | 2, 787 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 51. 9 |
| Skilled nursing facilities | 7. 0 |
| Home health agencies | 16 |
| Independent laboratories | 32 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 142. 5 |
| Skilled nursing facilities admissions | 4. 3 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 351. 4 |
| Skilled nursing facilities admissions | 10. 7 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 22. 8 |
| Skilled nursing facility admissions | 0. 2 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 415. 5 |
| Skilled nursing facility admissions | 3. 0 |

### DISTRICT OF COLUMBIA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 72, 690 |
| Supplementary medical insurance (SMI) | 69, 946 |
| HI and/or SMI | 69, 706 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $32, 294, 264 |
| SMI: Total | $14, 070, 823 |
| HI: Amount per HI enrollee | $448 |
| SMI: Amount per SMI enrollee | $202 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 17 |
| Short-stay | 13 |
| Tuberculosis | 0 |
| Psychiatric | 3 |
| Other long-stay | 1 |
| Skilled nursing facilities | 5 |

Footnotes at end of table.

## TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds: | |
| All hospitals | 9, 068 |
| Short-stay | 4, 630 |
| Tuberculosis | 0 |
| Psychiatric | 3, 987 |
| Other long-stay | 451 |
| Skilled nursing facilities | 641 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 70. 7 |
| Skilled nursing facilities | 9. 8 |
| Home health agencies | 3 |
| Independent laboratories | 4 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 22. 8 |
| Skilled nursing facilities admissions | 0. 5 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 347. 3 |
| Skilled nursing facilities admissions | 8. 1 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 2. 5 |
| Skilled nursing facility admissions | ([3]) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 392. 9 |
| Skilled nursing facility admissions | 2 |

### HAWAII

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 59, 733 |
| Supplementary medical insurance (SMI) | 58, 750 |
| HI and/or SMI | 55, 945 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $17, 475, 774 |
| SMI: Total | $9, 491, 640 |
| HI: Amount per HI enrollee | $300 |
| SMI: Amount per SMI enrollee | $165 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 27 |
| Short-stay | 22 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 4 |
| Skilled nursing facilities | 16 |
| Beds: | |
| All hospitals | 2, 791 |
| Short-stay | 2, 178 |
| Tuberculosis | 0 |
| Psychiatric | 350 |
| Other long-stay | 263 |
| Skilled nursing facilities | 1, 413 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 41. 8 |
| Skilled nursing facilities | 27. 1 |
| Home health agencies | 4 |
| Independent laboratories | 17 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 14.9 |
| Skilled nursing facilities admissions | 1.3 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 278.2 |
| Skilled nursing facilities admissions | 24.4 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 1.7 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 363 |
| Skilled nursing facility admissions | 10.1 |

IDAHO

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 85,803 |
| Supplementary medical insurance (SMI) | 83,463 |
| HI and/or SMI | 79,183 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $24,788,241 |
| SMI: Total | $9,184,552 |
| HI: Amount per HI enrollee | $296 |
| SMI: Amount per SMI enrollee | $107 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 46 |
| Short-stay | 46 |
| Tuberculosis | 0 |
| Psychiatric | 0 |
| Other long-stay | 0 |
| Skilled nursing facilities | 28 |
| Beds: | |
| All hospitals | 2,548 |
| Short-stay | 2,548 |
| Tuberculosis | 0 |
| Psychiatric | 0 |
| Other long-stay | 0 |
| Skilled nursing facilities | 1,588 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 334 |
| Skilled nursing facilities | 20.8 |
| Home health agencies | 9 |
| Independent laboratories | 6 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 26.3 |
| Skilled nursing facilities admissions | 1.7 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 341.2 |
| Skilled nursing facilities admissions | 21.8 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 2.5 |
| Skilled nursing facility admissions | 0.1 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 378.2 |
| Skilled nursing facility admissions | 7.8 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

### ILLINOIS

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 1, 221, 656 |
| Supplementary medical insurance (SMI) | 1, 194, 063 |
| HI and/or SMI | 1, 151, 045 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $439, 109, 928 |
| SMI: Total | $138, 307, 133 |
| HI: Amount per HI enrollee | $363 |
| SMI: Amount per SMI enrollee | $117 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 280 |
| Short-stay | 258 |
| Tuberculosis | 1 |
| Psychiatric | 17 |
| Other long-stay | 14 |
| Skilled nursing facilities | 173 |
| Beds: | |
| All hospitals | 53, 968 |
| Short-stay | 50, 292 |
| Tuberculosis | 143 |
| Psychiatric | 3, 043 |
| Other long-stay | 490 |
| Skilled nursing facilities | 7, 919 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 44. 6 |
| Skilled nursing facilities | 7. 0 |
| Home health agencies | 8. 1 |
| Independent laboratories | 202 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 373. 7 |
| Skilled nursing facilities admissions | 16. 8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 330. 5 |
| Skilled nursing facilities admissions | 14. 8 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 29. 7 |
| Skilled nursing facility admissions | 0. 5 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 379. 8 |
| Skilled nursing facility admissions | 6. 1 |

### INDIANA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 569, 941 |
| Supplementary medical insurance (SMI) | 553, 346 |
| HI and/or SMI | 528, 562 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $176, 650, 681 |
| SMI: Total | $57, 876, 595 |
| HI: Amount per HI enrollee | $315 |
| SMI: Amount per SMI enrollee | $106 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 130 |
| Short-stay | 119 |
| Tuberculosis | 0 |
| Psychiatric | 8 |
| Other long-stay | 3 |
| Skilled nursing facilities | 108 |
| Beds: | |
| All hospitals | 27, 009 |
| Short-stay | 22, 131 |
| Tuberculosis | 0 |
| Psychiatric | 4, 707 |
| Other long-stay | 171 |
| Skilled nursing facilities | 5, 189 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 42. 6 |
| Skilled nursing facilities | 10. 0 |
| Home health agencies | 29 |
| Independent laboratories | 35 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 165. 6 |
| Skilled nursing facilities admissions | 9. 7 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 318. 2 |
| Skilled nursing facilities admissions | 18. 6 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 15. 3 |
| Skilled nursing facility admissions | 0. 3 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 375. 1 |
| Skilled nursing facility admissions | 7 |

IOWA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 387, 060 |
| Supplementary medical insurance (SMI) | 379, 767 |
| HI and/or SMI | 366, 680 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $117, 593, 518 |
| SMI: Total | $35, 001, 613 |
| HI: Amount per HI enrollee | $306 |
| SMI: Amount per SMI enrollee | $93 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 171 |
| Short-stay | 140 |
| Tuberculosis | 1 |
| Psychiatric | 5 |
| Other long-stay | 25 |
| Skilled nursing facilities | 32 |
| Beds: | |
| All hospitals | 17, 261 |
| Short-stay | 14, 707 |
| Tuberculosis | 93 |
| Psychiatric | 1, 459 |
| Other long-stay | 1, 002 |
| Skilled nursing facilities | 915 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 40. 6 |
| Skilled nursing facilities | 2. 5 |
| Home health agencies | 64 |
| Independent laboratories | 14 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 135. 7 |
| Skilled nursing facilities admissions | 3. 9 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 374. 3 |
| Skilled nursing facilities admissions | 10. 9 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 9. 7 |
| Skilled nursing facility admissions | 0. 2 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 455. 9 |
| Skilled nursing facility admissions | 7. 1 |
| KANSAS | |
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 298, 998 |
| Supplementary medical insurance (SMI) | 292, 466 |
| HI and/or SMI | 284, 713 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $98, 963, 619 |
| SMI: Total | $34, 452, 660 |
| HI: Amount per HI enrollee | $334 |
| SMI: Amount per SMI enrollee | $119 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 185 |
| Short-stay | 152 |
| Tuberculosis | 1 |
| Psychiatric | 5 |
| Other long-stay | 27 |
| Skilled nursing facilities | 29 |
| Beds: | |
| All hospitals | 15, 311 |
| Short-stay | 12, 190 |
| Tuberculosis | 40 |
| Psychiatric | 2, 177 |
| Other long-stay | 904 |
| Skilled nursing facilities | 1, 564 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 43. 6 |
| Skilled nursing facilities | 5. 6 |
| Home health agencies | 34 |
| Independent laboratories | 23 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 112. 1 |
| Skilled nursing facilities admissions | 2. 8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 399. 6 |
| Skilled nursing facilities admissions | 10 |

Footnotes at end of table.

## TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 7. 2 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 466. 6 |
| Skilled nursing facility admissions | 3. 7 |

KENTUCKY

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 405, 843 |
| Supplementary medical insurance (SMI) | 400, 640 |
| HI and/or SMI | 368, 443 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $108, 154, 450 |
| SMI: Total | $28, 851, 498 |
| HI: Amount per HI enrollee | $270 |
| SMI: Amount per SMI enrollee | $73 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 116 |
| Short-stay | 102 |
| Tuberculosis | 4 |
| Psychiatric | 6 |
| Other long-stay | 4 |
| Skilled nursing facilities | 84 |
| Beds: | |
| All hospitals | 17, 318 |
| Short-stay | 13, 574 |
| Tuberculosis | 340 |
| Psychiatric | 3, 089 |
| Other long-stay | 315 |
| Skilled nursing facilities | 5, 289 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 38. 1 |
| Skilled nursing facilities | 14. 8 |
| Home health agencies | 40 |
| Independent laboratories | 36 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 126. 3 |
| Skilled nursing facilities admissions | 8. 7 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 351. 8 |
| Skilled nursing facilities admissions | 24. 4 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 15. 6 |
| Skilled nursing facility admissions | 0. 4 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 373. 1 |
| Skilled nursing facility admissions | 10. 1 |

LOUISIANA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 380, 644 |
| Supplementary medical insurance (SMI) | 353, 872 |
| HI and/or SMI | 341, 295 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $94, 340, 547 |
| SMI: Total | $34, 616, 997 |
| HI: Amount per HI enrollee | $253 |
| SMI: Amount per SMI enrollee | $99 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 141 |
| Short-stay | 132 |
| Tuberculosis | 1 |
| Psychiatric | 7 |
| Other long-stay | 1 |
| Skilled nursing facilities | 11 |
| Beds: | |
| All hospitals | 19, 202 |
| Short-stay | 16, 374 |
| Tuberculosis | 195 |
| Psychiatric | 2, 569 |
| Other long-stay | 64 |
| Skilled nursing facilities | 1, 127 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 49. 8 |
| Skilled nursing facilities | 3. 4 |
| Home health agencies | 74 |
| Independent laboratories | 35 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 125 |
| Skilled nursing facilities admissions | 2. 5 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 377. 1 |
| Skilled nursing facilities admissions | 7. 4 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 14. 4 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 343. 5 |
| Skilled nursing facility admissions | 1. 8 |

## MAINE

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 139, 832 |
| Supplementary medical insurance (SMI) | 137, 765 |
| HI and/or SMI | 130, 241 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $43, 227, 880 |
| SMI: Total | $14, 014, 948 |
| HI: Amount per HI enrollee | $315 |
| SMI: Amount per SMI enrollee | $103 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 54 |
| Short-stay | 52 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 1 |
| Skilled nursing facilities | 17 |

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds: | |
| All hospitals | 5, 007 |
| Short-stay | 4, 366 |
| Tuberculosis | NA |
| Psychiatric | 500 |
| Other long-stay | 141 |
| Skilled nursing facilities | 687 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 34. 5 |
| Skilled nursing facilities | 5. 4 |
| Home health agencies | 19 |
| Independent laboratories | 0 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 40. 3 |
| Skilled nursing facilities admissions | 1. 8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 317. 5 |
| Skilled nursing facilities admissions | 14. 2 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 3. 6 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 343. 6 |
| Skilled nursing facility admissions | 6. 5 |

MARYLAND

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 351, 835 |
| Supplementary medical insurance (SMI) | 342, 090 |
| HI and/or SMI | 330, 099 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $134, 011, 717 |
| SMI: Total | $47, 219, 535 |
| HI: Amount per HI enrollee | $387 |
| SMI: Amount per SMI enrollee | $140 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 62 |
| Short-stay | 47 |
| Tuberculosis | 2 |
| Psychiatric | 7 |
| Other long-stay | 6 |
| Skilled nursing facilities | 67 |
| Beds: | |
| All hospitals | 21, 363 |
| Short-stay | 12, 422 |
| Tuberculosis | 488 |
| Psychiatric | 7, 457 |
| Other long-stay | 996 |
| Skilled nursing facilities | 5, 490 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 39. 2 |
| Skilled nursing facilities | 17. 3 |
| Home health agencies | 26 |
| Independent laboratories | 70 |

Footnotes at end of table.

### TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 79. 4 |
| Skilled nursing facilities admissions | 6. 1 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 248. 1 |
| Skilled nursing facilities admissions | 18. 9 |
| Admissions (in thousands) during calendar year 1974, disabled perons: | |
| All hospital inpatient admissions | 8. 6 |
| Skilled nursing facility admissions | 0. 2 |
| Admission rte per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 329. 8 |
| Skilled nursing facility admissions | 5. 8 |
| MASSACHUSETTS | |
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 705, 669 |
| Supplementary medical insurance (SMI) | 691, 528 |
| HI and/or SMI | 667, 405 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $336, 315, 358 |
| SMI: Total | $99, 207, 871 |
| HI: Amount per HI enrollee | $482 |
| SMI: Amount per SMI enrollee | $145 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 172 |
| Short-stay | 135 |
| Tuberculosis | 3 |
| Psychiatric | 17 |
| Other long-stay | 17 |
| Skilled nursing facilities | 95 |
| Beds: | |
| All hospitals | 34, 703 |
| Short-stay | 26, 043 |
| Tuberculosis | 375 |
| Psychiatric | 3, 158 |
| Other long-stay | 5, 127 |
| Skilled nursing facilities | 5, 880 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 39. 9 |
| Skilled nursing facilities | 9. 0 |
| Home health agencies | 159 |
| Independent laboratories | 124 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 211. 2 |
| Skilled nursing facilities admissions | 11. 8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 322. 7 |
| Skilled nursing facilities admissions | 18. 1 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 14. 6 |
| Skilled nursing facility admissions | 0. 4 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 338. 3 |
| Skilled nursing facility admissions | 8. 7 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

## MICHIGAN

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 904, 210 |
| Supplementary medical insurance (SMI) | 884, 121 |
| HI and/or SMI | 824, 188 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $373, 739, 250 |
| SMI: Total | $116, 594, 567 |
| HI: Amount per HI enrollee | $422 |
| SMI: Amount per SMI enrollee | $134 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 241 |
| Short-stay | 218 |
| Tuberculosis | 0 |
| Psychiatric | 16 |
| Other long-stay | 7 |
| Skilled nursing facilities | 144 |
| Beds: | |
| All hospitals | 46, 265 |
| Short-stay | 37, 430 |
| Tuberculosis | 0 |
| Psychiatric | 7, 667 |
| Other long-stay | 1, 168 |
| Skilled nursing facilities | 11, 906 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 46. 5 |
| Skilled nursing facilities | 14. 8 |
| Home health agencies | 48 |
| Independent laboratories | 115 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 253 |
| Skilled nursing facilities admissions | 14. 6 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 313. 6 |
| Skilled nursing facilities admissions | 18. 1 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 27 |
| Skilled nursing facility admissions | 0. 6 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 340. 2 |
| Skilled nursing facility admissions | 7. 4 |

## MINNESOTA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 464, 060 |
| Supplementary medical insurance (SMI) | 457, 181 |
| HI and/or SMI | 441, 488 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $178, 089, 541 |
| SMI: Total | $57, 310, 818 |
| HI: Amount per HI enrollee | $389 |
| SMI: Amount per SMI enrollee | $127 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 194 |
| Short-stay | 181 |
| Tuberculosis | 1 |
| Psychiatric | 8 |
| Other long-stay | 4 |
| Skilled nursing facilities | 83 |
| Beds: | |
| All hospitals | 25, 162 |
| Short-stay | 20, 537 |
| Tuberculosis | 50 |
| Psychiatric | 4, 501 |
| Other long-stay | 74 |
| Skilled nursing facilities | 4, 301 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 47. 5 |
| Skilled nursing facilities | 10. 0 |
| Home health agencies | 61 |
| Independent laboratories | 15 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 172. 6 |
| Skilled nursing facilities admissions | 7. 5 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 398 |
| Skilled nursing facilities admissions | 17. 4 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 12. 7 |
| Skilled nursing facility admissions | 0. 2 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 518. 6 |
| Skilled nursing facility admissions | 8. 6 |

MISSISSIPPI

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 278, 978 |
| Supplementary medical insurance (SMI) | 273, 222 |
| HI and/or SMI | 253, 015 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $67, 768, 166 |
| SMI: Total | $28, 382, 442 |
| HI: Amount per HI enrollee | $248 |
| SMI: Amount per SMI enrollee | $106 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 113 |
| Short-stay | 111 |
| Tuberculosis | 1 |
| Psychiatric | 1 |
| Other long-stay | 0 |
| Skilled nursing facilities | 19 |
| Beds: | |
| All hospitals | 10, 498 |
| Short-stay | 10, 259 |
| Tuberculosis | 211 |
| Psychiatric | 28 |
| Other long-stay | 0 |
| Skilled nursing facilities | 755 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 42. 6 |
| Skilled nursing facilities | 3. 1 |
| Home health agencies | 89 |
| Independent laboratories | 15 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 100. 2 |
| Skilled nursing facilities admissions | 0. 8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 412. 5 |
| Skilled nursing facilities admissions | 3. 3 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 13. 1 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 427. 3 |
| Skilled nursing facility admissions | 1 |

MISSOURI

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 639, 034 |
| Supplementary medical insurance (SMI) | 625, 397 |
| HI and/or SMI | 597, 315 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $190, 990, 471 |
| SMI: Total | $67, 570, 872 |
| HI: Amount per HI enrollee | $302 |
| SMI: Amount per SMI enrollee | $109 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 175 |
| Short-stay | 157 |
| Tuberculosis | 0 |
| Psychiatric | 10 |
| Other long-stay | 8 |
| Skilled nursing facilities | 55 |
| Beds: | |
| All hospitals | 31, 271 |
| Short-stay | 25, 539 |
| Tuberculosis | 0 |
| Psychiatric | 4, 801 |
| Other long-stay | 931 |
| Skilled nursing facilities | 2, 855 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 43. 8 |
| Skilled nursing facilities | 4. 9 |
| Home health agencies | 34 |
| Independent laboratories | 64 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 215. 9 |
| Skilled nursing facilities admissions | 6 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 368. 7 |
| Skilled nursing facilities admissions | 10. 3 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 21 |
| Skilled nursing facility admissions | 0. 2 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 457. 5 |
| Skilled nursing facility admissions | 4. 8 |
| MONTANA | |
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 81, 519 |
| Supplementary medical insurance (SMI) | 79, 549 |
| HI and/or SMI | 75, 322 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $20, 981, 776 |
| SMI: Total | $8, 840, 118 |
| HI: Amount per HI enrollee | $262 |
| SMI: Amount per SMI enrollee | $113 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 61 |
| Short-stay | 60 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 0 |
| Skilled nursing facilities | 26 |
| Beds: | |
| All hospitals | 3, 601 |
| Short-stay | 3, 477 |
| Tuberculosis | 0 |
| Psychiatric | 124 |
| Other long-stay | 0 |
| Skilled nursing facilities | 870 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 47. 4 |
| Skilled nursing facilities | 11. 9 |
| Home health agencies | 10 |
| Independent laboratories | 7 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 31 |
| Skilled nursing facilities admissions | 0. 8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 420. 6 |
| Skilled nursing facilities admissions | 10. 7 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 2. 9 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 460. 7 |
| Skilled nursing facility admissions | 4. 9 |
| NEBRASKA | |
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 203, 128 |
| Supplementary medical insurance (SMI) | 198, 534 |
| HI and/or SMI | 193, 673 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $58, 022, 474 |
| SMI: Total | $21, 428, 126 |
| HI: Amount per HI enrollee | $288 |
| SMI: Amount per SMI enrollee | $109 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 121 |
| Short-stay | 103 |
| Tuberculosis | 0 |
| Psychiatric | 5 |
| Other long-stay | 13 |
| Skilled nursing facilities | 5 |
| Beds: | |
| All hospitals | 9, 344 |
| Short-stay | 8, 090 |
| Tuberculosis | 0 |
| Psychiatric | 658 |
| Other long-stay | 596 |
| Skilled nursing facilities | 806 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 42. 5 |
| Skilled nursing facilities | 4. 2 |
| Home health agencies | 12 |
| Independent laboratories | 7 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 77. 1 |
| Skilled nursing facilities admissions | 4. 8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 403. 5 |
| Skilled nursing facilities admissions | 468. 3 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 2. 2 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 11. 7 |
| Skilled nursing facility admissions | 3. 7 |

NEVADA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 46, 836 |
| Supplementary medical insurance (SMI) | 45, 335 |
| HI and/or SMI | 42, 829 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $18, 048, 001 |
| SMI: Total | $8, 403, 384 |
| HI: Amount per HI enrollee | $399 |
| SMI: Amount per SMI enrollee | $191 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 23 |
| Short-stay | 21 |
| Tuberculosis | 0 |
| Psychiatric | 2 |
| Other long-stay | 0 |
| Skilled nursing facilities | 19 |
| Beds: | |
| All hospitals | 3, 104 |
| Short-stay | 2, 629 |
| Tuberculosis | 0 |
| Psychiatric | 475 |
| Other long-stay | 0 |
| Skilled nursing facilities | 629 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 66. 3 |
| Skilled nursing facilities | 15. 9 |
| Home health agencies | 3 |
| Independent laboratories | 20 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 15. 3 |
| Skilled nursing facilities admissions | 1. 5 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 372. 9 |
| Skilled nursing facilities admissions | 35. 9 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 2. 1 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 491. 8 |
| Skilled nursing facility admissions | 14. 9 |
| NEW HAMPSHIRE | |
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 96, 406 |
| Supplementary medical insurance (SMI) | 93, 095 |
| HI and/or SMI | 90, 726 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $29, 698, 306 |
| SMI: Total | $10, 059, 408 |
| HI: Amount per HI enrollee | $315 |
| SMI: Amount per SMI enrollee | $110 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 31 |
| Short-stay | 29 |
| Tuberculosis | 0 |
| Psychiatric | 2 |
| Other long-stay | 0 |
| Skilled nursing facilities | 20 |
| Beds: | |
| All hospitals | 4, 987 |
| Short-stay | 3, 044 |
| Tuberculosis | 0 |
| Psychiatric | 1, 943 |
| Other long-stay | 0 |
| Skilled nursing facilities | 1, 006 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 34. 4 |
| Skilled nursing facilities | 11. 4 |
| Home health agencies | 40 |
| Independent laboratories | 4 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 28. 7 |
| Skilled nursing facilities admissions | 2. 4 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 324. 5 |
| Skilled nursing facilities admissions | 26. 8 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 1. 9 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 335. 6 |
| Skilled nursing facility admissions | 9. 9 |

NEW JERSEY

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 810, 665 |
| Supplementary medical insurance (SMI) | 796, 802 |
| HI and/or SMI | 756, 824 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $282, 995, 262 |
| SMI: Total | $124, 623, 785 |
| HI: Amount per HI enrollee | $355 |
| SMI: Amount per SMI enrollee | $159 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 130 |
| Short-stay | 107 |
| Tuberculosis | 1 |
| Psychiatric | 12 |
| Other long-stay | 10 |
| Skilled nursing facilities | 125 |
| Beds: | |
| All hospitals | 41, 661 |
| Short-stay | 27, 867 |
| Tuberculosis | 275 |
| Psychiatric | 12, 343 |
| Other long-stay | 1, 176 |
| Skilled nursing facilities | 9, 249 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 37. 8 |
| Skilled nursing facilities | 12. 6 |
| Home health agencies | 44 |
| Independent laboratories | 112 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 198. 2 |
| Skilled nursing facilities admissions | 18. 1 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 267. 3 |
| Skilled nursing facilities admissions | 24. 4 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 18. 5 |
| Skilled nursing facility admissions | 0. 5 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 330. 8 |
| Skilled nursing facility admissions | 8. 4 |

NEW MEXICO

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 98, 625 |
| Supplementary medical insurance (SMI) | 95, 617 |
| HI and/or SMI | 90, 122 |

Footnotes at end of table.

### TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $27, 542, 183 |
| SMI: Total | $11, 575, 652 |
| HI: Amount per HI enrollee | $286 |
| SMI: Amount per SMI enrollee | $124 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 41 |
| Short-stay | 39 |
| Tuberculosis | 0 |
| Psychiatric | 2 |
| Other long-stay | 0 |
| Skilled nursing facilities | 7 |
| Beds: | |
| All hospitals | 3, 637 |
| Short-stay | 3, 501 |
| Tuberculosis | 0 |
| Psychiatric | 136 |
| Other long-stay | 0 |
| Skilled nursing facilities | 323 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 41. 3 |
| Skilled nursing facilities | 3. 8 |
| Home health agencies | 7 |
| Independent laboratories | 25 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 27. 5 |
| Skilled nursing facilities admissions | . 6 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 317. 5 |
| Skilled nursing facilities admissions | 6. 9 |
| Admissions (in thousands) during calendar year 1974, disabled perons: | |
| All hospital inpatient admissions | 3 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 312. 3 |
| Skilled nursing facility admissions | 2. 1 |

#### NEW YORK

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 2, 177, 043 |
| Supplementary medical insurance (SMI) | 2, 123, 744 |
| HI and/or SMI | 2, 035, 715 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $979, 761, 975 |
| SMI: Total | $375, 373, 505 |
| HI: Amount per HI enrollee | $456 |
| SMI: Amount per SMI enrollee | $179 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 398 |
| Short-stay | 338 |
| Tuberculosis | 1 |
| Psychiatric | 39 |
| Other long-stay | 20 |
| Skilled nursing facilities | 357 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds: | |
| All hospitals | 125, 731 |
| Short-stay | 77, 551 |
| Tuberculosis | 46 |
| Psychiatric | 43, 530 |
| Other long-stay | 4, 604 |
| Skilled nursing facilities | 45, 690 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 38. 8 |
| Skilled nursing facilities | 22. 9 |
| Home health agencies | 124 |
| Independent laboratories | 240 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 558 |
| Skilled nursing facilities admissions | 44. 4 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 279. 1 |
| Skilled nursing facilities admissions | 22. 2 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 49. 7 |
| Skilled nursing facility admissions | 1. 3 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 327. 9 |
| Skilled nursing facility admissions | 8. 8 |

### NORTH CAROLINA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 541, 164 |
| Supplementary medical insurance (SMI) | 529, 907 |
| HI and/or SMI | 486, 587 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $141, 491, 702 |
| SMI: Total | $45, 403, 954 |
| HI: Amount per HI enrollee | $268 |
| SMI: Amount per SMI enrollee | $88 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 152 |
| Short-stay | 138 |
| Tuberculosis | 2 |
| Psychiatric | 5 |
| Other long-stay | 7 |
| Skilled nursing facilities | 89 |
| Beds: | |
| All hospitals | 28, 768 |
| Short-stay | 20, 107 |
| Tuberculosis | 442 |
| Psychiatric | 7, 124 |
| Other long-stay | 1, 095 |
| Skilled nursing facilities | 6, 086 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 43. 5 |
| Skilled nursing facilities | 13. 2 |
| Home health agencies | 61 |
| Independent laboratories | 11 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 152. 1 |
| Skilled nursing facilities admissions | 8. 1 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 324. 3 |
| Skilled nursing facilities admissions | 17. 2 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 23. 1 |
| Skilled nursing facility admissions | 0. 3 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 398. 8 |
| Skilled nursing facility admissions | 5. 1 |

### NORTH DAKOTA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 78, 256 |
| Supplementary medical insurance (SMI) | 76, 456 |
| HI and/or SMI | 73, 969 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $27, 384, 050 |
| SMI: Total | $8, 619, 094 |
| HI: Amount per HI enrollee | $355 |
| SMI: Amount per SMI enrollee | $114 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 56 |
| Short-stay | 53 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 2 |
| Skilled nursing facilities | 3 |
| Beds: | |
| All hospitals | 4, 578 |
| Short-stay | 3, 473 |
| Tuberculosis | 0 |
| Psychiatric | 943 |
| Other long-stay | 162 |
| Skilled nursing facilities | 46 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 48. 2 |
| Skilled nursing facilities | 0. 6 |
| Home health agencies | 9 |
| Independent laboratories | 9 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 34. 3 |
| Skilled nursing facilities admissions | 0. 4 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 472. 9 |
| Skilled nursing facilities admissions | 5. 8 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 2. 4 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 508. 7 |
| Skilled nursing facility admissions | 1. 5 |

Footnotes at end of table.

### Table 2.—*State data on the medicare program*—Continued

OHIO

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 1, 146, 841 |
| Supplementary medical insurance (SMI) | 1, 113, 782 |
| HI and/or SMI | 1, 062, 933 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $386, 727, 592 |
| SMI: Total | $108, 590, 597 |
| HI: Amount per HI enrollee | $342 |
| SMI: Amount per SMI enrollee | $99 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 235 |
| Short-stay | 208 |
| Tuberculosis | 3 |
| Psychiatric | 16 |
| Other long-stay | 8 |
| Skilled nursing facilities | 183 |
| Beds: | |
| All hospitals | 50, 367 |
| Short-stay | 44, 501 |
| Tuberculosis | 489 |
| Psychiatric | 3, 973 |
| Other long-stay | 1, 404 |
| Skilled nursing facilities | 14, 229 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 42. 9 |
| Skilled nursing facilities | 13. 7 |
| Home health agencies | 103 |
| Independent laboratories | 97 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 322. 6 |
| Skilled nursing facilities admissions | 24. 5 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 310. 1 |
| Skilled nursing facilities admissions | 23. 5 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 32. 1 |
| Skilled nursing facility admissions | 0. 7 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 359. 2 |
| Skilled nursing facility admissions | 8. 2 |

OKLAHOMA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 352, 889 |
| Supplementary medical insurance (SMI) | 346, 388 |
| HI and/or SMI | 328, 506 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $102, 521, 536 |
| SMI: Total | $39, 385, 837 |
| HI: Amount per HI enrollee | $295 |
| SMI: Amount per SMI enrollee | $115 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 129 |
| Short-stay | 123 |
| Tuberculosis | 1 |
| Psychiatric | 5 |
| Other long-stay | 0 |
| Skilled nursing facilities | 7 |
| Beds: | |
| All hospitals | 12, 790 |
| Short-stay | 11, 721 |
| Tuberculosis | 127 |
| Psychiatric | 942 |
| Other long-stay | 0 |
| Skilled nursing facilities | 434 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 36. 9 |
| Skilled nursing facilities | 1. 4 |
| Home health agencies | 51 |
| Independent laboratories | 47 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 123. 2 |
| Skilled nursing facilities admissions | 1. 8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 386. 2 |
| Skilled nursing facilities admissions | 5. 6 |
| Admissions (in thousands) during calendar year 1974, disabled perons: | |
| All hospital inpatient admissions | 11. 6 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 402. 6 |
| Skilled nursing facility admissions | 2. 5 |

OREGON

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 277, 250 |
| Supplementary medical insurance (SMI) | 265, 715 |
| HI and/or SMI | 254, 812 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $81, 613, 827 |
| SMI: Total | $31, 351, 426 |
| HI: Amount per HI enrollee | $300 |
| SMI: Amount per SMI enrollee | $120 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 85 |
| Short-stay | 78 |
| Tuberculosis | 0 |
| Psychiatric | 5 |
| Other long-stay | 2 |
| Skilled nursing facilities | 51 |
| Beds: | |
| All hospitals | 9, 586 |
| Short-stay | 7, 793 |
| Tuberculosis | 0 |
| Psychiatric | 1, 734 |
| Other long-stay | 59 |
| Skilled nursing facilities | 2, 150 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 31. 5 |
| Skilled nursing facilities | 8. 7 |
| Home health agencies | 25 |
| Independent laboratories | 41 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 80. 6 |
| Skilled nursing facilities admissions | 5. 9 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 322. 4 |
| Skilled nursing facilities admissions | 23. 5 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 8. 4 |
| Skilled nursing facility admissions | 0. 2 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 386. 2 |
| Skilled nursing facility admissions | 7. 9 |

PENNSYLVANIA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 1, 475, 946 |
| Supplementary medical insurance (SMI) | 1, 438, 622 |
| HI and/or SMI | 1, 368, 538 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $462, 838, 399 |
| SMI: Total | $180, 431, 607 |
| HI: Amount per HI enrollee | $318 |
| SMI: Amount per SMI enrollee | $127 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 282 |
| Short-stay | 243 |
| Tuberculosis | 0 |
| Psychiatric | 29 |
| Other long-stay | 10 |
| Skilled nursing facilities | 172 |
| Beds: | |
| All hospitals | 75, 867 |
| Short-stay | 50, 673 |
| Tuberculosis | 0 |
| Psychiatric | 24, 502 |
| Other long-stay | 692 |
| Skilled nursing facilities | 12, 569 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 37. 9 |
| Skilled nursing facilities | 9. 4 |
| Home health agencies | 101 |
| Independent laboratories | 143 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 395 |
| Skilled nursing facilities admissions | 24. 2 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 293. 9 |
| Skilled nursing facilities admissions | 18 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar year 1974, disabled perons: | |
| All hospital inpatient admissions | 38. 9 |
| Skilled nursing facility admissions | 0. 6 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 350. 1 |
| Skilled nursing facility admissions | 5. 6 |

RHODE ISLAND

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 121, 349 |
| Supplementary medical insurance (SMI) | 118, 611 |
| HI and/or SMI | 112, 773 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $49, 252, 203 |
| SMI: Total | $19, 243, 955 |
| HI: Amount per HI enrollee | $412 |
| SMI: Amount per SMI enrollee | $165 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 18 |
| Short-stay | 14 |
| Tuberculosis | 0 |
| Psychiatric | 2 |
| Other long-stay | 2 |
| Skilled nursing facilities | 21 |
| Beds: | |
| All hospitals | 6, 903 |
| Short-stay | 3, 289 |
| Tuberculosis | 0 |
| Psychiatric | 2, 037 |
| Other long-stay | 1, 577 |
| Skilled nursing facilities | 1, 133 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 29. 9 |
| Skilled nursing facilities | 10. 3 |
| Home health agencies | 13 |
| Independent laboratories | 21 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 31. 5 |
| Skilled nursing facilities admissions | 3 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 285 |
| Skilled nursing facilities admissions | 27. 4 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 27. 1 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 303. 2 |
| Skilled nursing facility admissions | 11. 2 |

SOUTH CAROLINA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 259, 508 |
| Supplementary medical insurance (SMI) | 251, 909 |
| HI and/or SMI | 228, 168 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $62, 667, 753 |
| SMI: Total | $19, 665, 783 |
| HI: Amount per HI enrollee | $248 |
| SMI: Amount per SMI enrollee | $80 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 78 |
| Short-stay | 72 |
| Tuberculosis | 1 |
| Psychiatric | 4 |
| Other long-stay | 1 |
| Skilled nursing facilities | 71 |
| Beds: | |
| All hospitals | 15, 871 |
| Short-stay | 9, 535 |
| Tuberculosis | 566 |
| Psychiatric | 5, 412 |
| Other long-stay | 358 |
| Skilled nursing facilities | 4, 738 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 44. 3 |
| Skilled nursing facilities | 12. 0 |
| Home health agencies | 15 |
| Independent laboratories | 15 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 65 |
| Skilled nursing facilities admissions | 4. 1 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 297. 2 |
| Skilled nursing facilities admissions | 18. 8 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 11. 6 |
| Skilled nursing facility admissions | 0. 2 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 342. 8 |
| Skilled nursing facility admissions | 5. 2 |

SOUTH DAKOTA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 90, 601 |
| Supplementary medical insurance (SMI) | 88, 295 |
| HI and/or SMI | 85, 766 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $26, 803, 497 |
| SMI: Total | $7, 826, 157 |
| HI: Amount per HI enrollee | $299 |
| SMI: Amount per SMI enrollee | $89 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 60 |
| Short-stay | 59 |
| Tuberculosis | 0 |
| Psychiatric | 0 |
| Other long-stay | 1 |
| Skilled nursing facilities | 10 |

Footnotes at end of table.

## TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds: | |
| All hospitals | 3, 517 |
| Short-stay | 4, 365 |
| Tuberculosis | 0 |
| Psychiatric | 0 |
| Other long-stay | 52 |
| Skilled nursing facilities | 326 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 41. 1 |
| Skilled nursing facilities | 3. 9 |
| Home health agencies | 21 |
| Independent laboratories | 6 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 35. 5 |
| Skilled nursing facilities admissions | 0. 8 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 420. 3 |
| Skilled nursing facilities admissions | 9. 6 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 2. 1 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 390. 8 |
| Skilled nursing facility admissions | 4. 4 |

### TENNESSEE

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 481, 565 |
| Supplementary medical insurance (SMI) | 474, 202 |
| HI and/or SMI | 437, 934 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $118, 979, 055 |
| SMI: Total | $46, 767, 741 |
| HI: Amount per HI enrollee | $252 |
| SMI: Amount per SMI enrollee | $100 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 161 |
| Short-stay | 147 |
| Tuberculosis | 4 |
| Psychiatric | 7 |
| Other long-stay | 3 |
| Skilled nursing facilities | 38 |
| Beds: | |
| All hospitals | 23, 127 |
| Short-stay | 21, 881 |
| Tuberculosis | 350 |
| Psychiatric | 734 |
| Other long-stay | 162 |
| Skilled nursing facilities | 1, 383 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 52. 3 |
| Skilled nursing facilities | 3. 3 |
| Home health agencies | 96 |
| Independent laboratories | 23 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 163 |
| Skilled nursing facilities admissions | 4 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 384. 7 |
| Skilled nursing facilities admissions | 9. 4 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 22. 4 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 465 |
| Skilled nursing facility admissions | 2. 7 |
| TEXAS | |
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 1, 212, 285 |
| Supplementary medical insurance (SMI) | 1, 197, 276 |
| HI and/or SMI | 1, 136, 162 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $375, 336, 815 |
| SMI: Total | $159, 552, 667 |
| HI: Amount per HI enrollee | $316 |
| SMI: Amount per SMI enrollee | $136 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 496 |
| Short-stay | 468 |
| Tuberculosis | 3 |
| Psychiatric | 17 |
| Other long-stay | 8 |
| Skilled nursing facilities | 84 |
| Beds: | |
| All hospitals | 59, 894 |
| Short-stay | 52, 044 |
| Tuberculosis | 671 |
| Psychiatric | 6, 363 |
| Other long-stay | 816 |
| Skilled nursing facilities | 3, 040 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 48. 0 |
| Skilled nursing facilities | 2. 8 |
| Home health agencies | 47 |
| Independent laboratories | 155 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 442. 9 |
| Skilled nursing facilities admissions | 6. 4 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 403. 2 |
| Skilled nursing facilities admissions | 5. 8 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 39 |
| Skilled nursing facility admissions | 0. 2 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 430. 3 |
| Skilled nursing facility admissions | 2. 2 |

Footnotes at end of table.

## Table 2.—*State data on the medicare program*—Continued

### UTAH

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 95, 687 |
| Supplementary medical insurance (SMI) | 91, 408 |
| HI and/or SMI | 89, 410 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $20, 257, 300 |
| SMI: Total | $10, 583, 218 |
| HI: Amount per HI enrollee | $216 |
| SMI: Amount per SMI enrollee | $118 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 38 |
| Short-stay | 37 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 0 |
| Skilled nursing facilities | 14 |
| Beds: | |
| All hospitals | 3, 890 |
| Short-stay | 3, 551 |
| Tuberculosis | 0 |
| Psychiatric | 357 |
| Other long-stay | 0 |
| Skilled nursing facilities | 431 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 41. 3 |
| Skilled nursing facilities | 5. 0 |
| Home health agencies | 9 |
| Independent laboratories | 18 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 26. 5 |
| Skilled nursing facilities admissions | 1. 3 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 304 |
| Skilled nursing facilities admissions | 14. 9 |
| Admissions (in thousands) during calendar year 1974, disabled perons: | |
| All hospital inpatient admissions | 2. 1 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 320. 4 |
| Skilled nursing facility admissions | 4. 9 |

### VERMONT

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 57, 057 |
| Supplementary medical insurance (SMI) | 56, 464 |
| HI and/or SMI | 53, 750 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $21, 141, 282 |
| SMI: Total | $6, 460, 341 |
| HI: Amount per HI enrollee | $375 |
| SMI: Amount per SMI enrollee | $116 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 19 |
| Short-stay | 17 |
| Tuberculosis | 0 |
| Psychiatric | 2 |
| Other long-stay | 0 |
| Skilled nursing facilities | 21 |
| Beds: | |
| All hospitals | 2, 788 |
| Short-stay | 1, 900 |
| Tuberculosis | 0 |
| Psychiatric | 888 |
| Other long-stay | 0 |
| Skilled nursing facilities | 820 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 36. 2 |
| Skilled nursing facilities | 15. 6 |
| Home health agencies | 16 |
| Independent laboratories | 2 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 18. 3 |
| Skilled nursing facilities admissions | 2. 3 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 349. 2 |
| Skilled nursing facilities admissions | 43. 8 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 1. 7 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 427. 8 |
| Skilled nursing facility admissions | 20. 8 |

VIRGINIA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 457, 831 |
| Supplementary medical insurance (SMI) | 442, 880 |
| HI and/or SMI | 416, 693 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $121, 046, 223 |
| SMI: Total | $47, 573, 864 |
| HI: Amount per HI enrollee | $270 |
| SMI: Amount per SMI enrollee | $109 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 121 |
| Short-stay | 106 |
| Tuberculosis | 1 |
| Psychiatric | 11 |
| Other long-stay | 3 |
| Skilled nursing facilities | 36 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds: | |
| All hospitals | 22,192 |
| Short-stay | 19,354 |
| Tuberculosis | 322 |
| Psychiatric | 1,612 |
| Other long-stay | 904 |
| Skilled nursing facilities | 1,498 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 48.6 |
| Skilled nursing facilities | 3.8 |
| Home health agencies | 99 |
| Independent laboratories | 30 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 127.8 |
| Skilled nursing facilities admissions | 2.8 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 317.1 |
| Skilled nursing facilities admissions | 7 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 17.4 |
| Skilled nursing facility admissions | 0.1 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 380 |
| Skilled nursing facility admissions | 2.2 |
| WASHINGTON | |
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 387,914 |
| Supplementary medical insurance (SMI) | 378,157 |
| HI and/or SMI | 360,911 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $105,506,763 |
| SMI: Total | $48,214,886 |
| HI: Amount per HI enrollee | $277 |
| SMI: Amount per SMI enrollee | $130 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 118 |
| Short-stay | 111 |
| Tuberculosis | 2 |
| Psychiatric | 5 |
| Other long-stay | 0 |
| Skilled nursing facilities | 90 |
| Beds: | |
| All hospitals | 13,709 |
| Short-stay | 11,638 |
| Tuberculosis | 160 |
| Psychiatric | 1,911 |
| Other long-stay | 0 |
| Skilled nursing facilities | 3,106 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 33.3 |
| Skilled nursing facilities | 8.9 |
| Home health agencies | 22 |
| Independent laboratories | 63 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 115. 6 |
| Skilled nursing facilities admissions | 10. 1 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 327. 5 |
| Skilled nursing facilities admissions | 28. 6 |
| Admissions (in thousands) during calendar year 1974, disabled perons: | |
| All hospital inpatient admissions | 10. 8 |
| Skilled nursing facility admissions | 0. 3 |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 391. 2 |
| Skilled nursing facility admissions | 11. 8 |

WEST VIRGINIA

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 245, 526 |
| Supplementary medical insurance (SMI) | 240, 374 |
| HI and/or SMI | 213, 443 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $60, 198, 079 |
| SMI: Total | $17, 552, 648 |
| HI: Amount per HI enrollee | $249 |
| SMI: Amount per SMI enrollee | $74 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 75 |
| Short-stay | 78 |
| Tuberculosis | 0 |
| Psychiatric | 2 |
| Other long-stay | 0 |
| Skilled nursing facilities | 28 |
| Beds: | |
| All hospitals | 9, 503 |
| Short-stay | 9, 403 |
| Tuberculosis | 0 |
| Psychiatric | 100 |
| Other long-stay | 0 |
| Skilled nursing facilities | 1, 718 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 45. 8 |
| Skilled nursing facilities | 8. 3 |
| Home health agencies | 18 |
| Independent laboratories | 11 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 78. 9 |
| Skilled nursing facilities admissions | 1. 9 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 377. 6 |
| Skilled nursing facilities admissions | 8. 9 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 11. 7 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 355. 4 |
| Skilled nursing facility admissions | 2. 3 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

### WISCONSIN

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 547, 313 |
| Supplementary medical insurance (SMI) | 537, 652 |
| HI and/or SMI | 513, 391 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $183, 766, 279 |
| SMI: Total | $61, 161, 556 |
| HI: Amount per HI enrollee | $341 |
| SMI: Amount per SMI enrollee | $115 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 167 |
| Short-stay | 149 |
| Tuberculosis | 3 |
| Psychiatric | 10 |
| Other long-stay | 5 |
| Skilled nursing facilities | 56 |
| Beds: | |
| All hospitals | 23, 422 |
| Short-stay | 21, 087 |
| Tuberculosis | 82 |
| Psychiatric | 1, 873 |
| Other long-stay | 380 |
| Skilled nursing facilities | 3, 119 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 41. 9 |
| Skilled nursing facilities | 6. 2 |
| Home health agencies | 68 |
| Independent laboratories | 19 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 169. 7 |
| Skilled nursing facilities admissions | 5. 2 |
| Admission rate per 1,000 HI enrollees:[1] | |
| All hospital inpatient admissions | 336. 2 |
| Skilled nursing facilities admissions | 10. 4 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 14. 2 |
| Skilled nursing facility admissions | 0. 1 |
| Admission rate per 1,000 HI enrollees:[2] | |
| All hospital inpatient admissions | 406. 7 |
| Skilled nursing facility admissions | 3. 9 |

### WYOMING

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 36, 043 |
| Supplementary medical insurance (SMI) | 34, 894 |
| HI and/or SMI | 33, 898 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $9, 500, 575 |
| SMI: Total | $3, 242, 270 |
| HI: Amount per HI enrollee | $268 |
| SMI: Amount per SMI enrollee | $94 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 28 |
| Short-stay | 27 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 0 |
| Skilled nursing facilities | 2 |
| Beds: | |
| All hospitals | 1, 980 |
| Short-stay | 1, 612 |
| Tuberculosis | 0 |
| Psychiatric | 368 |
| Other long-stay | 0 |
| Skilled nursing facilities | 128 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 48. 9 |
| Skilled nursing facilities | 3. 9 |
| Home health agencies | 11 |
| Independent laboratories | 4 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | 12 |
| Skilled nursing facilities admissions | 0. 2 |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | 361. 7 |
| Skilled nursing facilities admissions | 7. 1 |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | 0. 8 |
| Skilled nursing facility admissions | (3) |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | 376 |
| Skilled nursing facility admissions | 2. 7 |

PUERTO RICO

| | |
|---|---|
| Persons enrolled as of Jan. 1, 1975, for: | |
| Hospital insurance (HI) | 255, 340 |
| Supplementary medical insurance (SMI) | 121, 452 |
| HI and/or SMI | 211, 257 |
| Amounts reimbursed during calendar year 1974: | |
| HI: Total | $26, 934, 033 |
| SMI: Total | $11, 101, 161 |
| HI: Amount per HI enrollee | $109 |
| SMI: Amount per SMI enrollee | $91 |
| Participating facilities as of July 1975: | |
| Number: | |
| All hospitals | 63 |
| Short-stay | 61 |
| Tuberculosis | 0 |
| Psychiatric | 1 |
| Other long-stay | 1 |
| Skilled nursing facilities | 5 |

Footnotes at end of table.

TABLE 2.—*State data on the medicare program*—Continued

| | |
|---|---|
| Participating facilities as of July 1975—Continued | |
| Beds: | |
| All hospitals | 7, 468 |
| Short-stay | 7, 086 |
| Tuberculosis | 0 |
| Psychiatric | 345 |
| Other long-stay | 37 |
| Skilled nursing facilities | 359 |
| Beds per 1,000 HI enrollees: | |
| Short-stay hospitals | 35. 1 |
| Skilled nursing facilities | 1. 8 |
| Home health agencies | 13 |
| Independent laboratories | 48 |
| Admissions (in thousands) during calendar 1974, persons aged 65 and over: | |
| All hospital inpatient admissions | NA |
| Skilled nursing facilities admissions | NA |
| Admission rate per 1,000 HI enrollees: [1] | |
| All hospital inpatient admissions | NA |
| Skilled nursing facilities admissions | NA |
| Admissions (in thousands) during calendar year 1974, disabled persons: | |
| All hospital inpatient admissions | NA |
| Skilled nursing facility admissions | NA |
| Admission rate per 1,000 HI enrollees: [2] | |
| All hospital inpatient admissions | NA |
| Skilled nursing facility admissions | NA |

[1] Based on number of persons aged 65 and over enrolled in the health insurance program as of July 1, 1974.

[2] Based on number of disabled persons enrolled in the health insurance program as of July 1, 1974.

[3] Less than 50.

NA=Not available.

Source: Office of Research and Statistics, Social Security Administration, Department of Health, Education, and Welfare.

# Chapter 2. Professional Standards Review Organizations (PSRO's) (Title XI of the Social Security Act)

## BACKGROUND

The 1972 Amendments to the Social Security Act provide for the creation of professional standards review organizations (PSRO's) designed to involve local practicing physicians in the ongoing review and evaluation of health care services covered under the medicare, medicaid, and the maternal and child health programs. The legislation is based on the concepts that health professionals are the most appropriate individuals to evaluate the quality of medical services and that effective peer review at the local level is the soundest method for assuring the appropriate use of health care resources and facilities. The PSRO is the means by which the legislation attempts to translate these concepts into practice.

Under title XI of the Social Security Act, as amended by the 1972 amendments, the Secretary of Health, Education, and Welfare is required to designate PSRO geographic areas throughout the United States no later than January 1, 1974. These initial area designations may be altered at any time changes in the boundaries appear warranted or necessary. Subsequent to the designation of areas, the Secretary is to enter into agreements with qualified organizations in each area. If such an organization does not apply to be a PSRO by that date, the Secretary can designate any other organization that he determines has the professional competence and is otherwise suitable to be a PSRO.

Qualified PSRO applicants are to be approved on a conditional basis for a period not to exceed 2 years. During this trial period, the Secretary may require the PSRO to perform only those functions it is capable of performing. The number and type of duties are to be progressively increased. By the end of the period such organization will be considered qualified only if the Secretary finds that it is substantially carrying out the functions required of a PSRO.

A National Professional Standards Review Council, consisting of 11 physicians of recognized standing in the review of medical practice is to be appointed by the Secretary. The National Council arranges for the collection and distribution of data and other information useful to PSRO's, particularly information relating to the development and application of norms, standards, and criteria for care. The National Council reports regularly to the Secretary and to the Congress on the overall effectiveness of the PSRO program and offers such recommendations as it might have for improvement of the progrram including specific pertinent data with respect to each PSRO.

## REVIEW RESPONSIBILITIES

The PSRO is responsible for assuring that health care paid for under medicare, medicaid, and maternal and child health programs is medically necessary and consistent with professionally recognized standards of care. It must also seek to encourage the use of less costly sites and modes of treatment where medically appropriate.

The PSRO is required to review services furnished in and by hospitals and other health care institutions, such as skilled nursing facilities. The review of other types of health care, such as ambulatory care, can be undertaken at the option of the individual PSRO and with the Secretary's approval. The internal review activities of hospitals and other health care institutions are to be utilized by the PSRO in carrying out its functions to the extent these activities are determined to be effective by the PSRO. The PSRO is also required to review institution, physician, and patient profiles, and to utilize regional norms of care in its review. Fiscal agents are required to abide by the PSRO's determination as to the medical necessity and appropriateness of services in paying medicare and medicaid claims.

## Hearings, Review, and Sanctions

The legislation further provides for hearings and review of PSRO determinations and includes sanctions for those cases that voluntary and educational efforts fail to correct. Persons who are engaged in required review activities or who provide information to the PSRO's in good faith are protected from civil liability for actions taken in proper performance of these duties. In addition, physicians and providers are exempt from civil liability arising from adherence to the recommendations of the review organization providing they exercise due care in the performance of their functions.

## Reimbursement

Expenses incurred in the administration of the program are payable in appropriate part from: (1) funds in the medicare part A trust fund, (2) funds in the medicare part B trust fund, and (3) funds appropriated under the medicaid and maternal and child health programs. In addition, beginning February 1, 1976, PSRO direct review activities (i.e., those not delegated to hospitals) are to be reimbursed by hospitals which in turn are to receive reimbursement in full for these payments from the medicare trust funds. Expenses for delegated review continue to be reimbursed through this mechanism.

# Chapter 3. Federal Income Tax Treatment of Health-Related Expenditures

Current Federal income tax law provides quite favorable tax treatment for certain health-related expenditures made by taxpayers. The resulting tax expenditures (reductions in Federal tax revenues that would otherwise be collected) amounted to more than $3.6 billion in 1974. In 1977, this figure is expected to rise more than $7.3 billion, an increase of more than 100 percent. Tax expenditures for health care take on three separate forms: the deductibility of medical expenses, the exclusion of health insurance premiums paid by employers for their employees, and the deductibility of charitable contributions primarily for health care.

## MEDICAL EXPENSES

Section 213 of the Internal Revenue Code of 1954 allows a deduction from adjusted gross income for medical expenses (not reimbursed by insurance) to the extent that the expenses exceed 3 percent of adjusted gross income. Expenditures for medicines and drugs can be included as medical expenses only to the extent that they alone exceed 1 percent of adjusted gross income. There is no maximum limitation on the amount of this deduction, and medical expenses paid on behalf of the taxpayer's dependents are also deductible.

Section 213(e) of the code defines medical expenses broadly to include any amount paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. The definition also includes transportation costs on trips primarily for and essential to medical care.

One-half of the cost of purchasing health insurance (up to a maximum of $150) is fully deductible as a medical expense without regard to the 3-percent floor applicable to other medical expenses. The other one-half of the premium (plus any amounts in excess of $150 in the first half) are includible as regular medical expenses—subject to the 3-percent floor on deductibility.

Social security taxes paid by employers, employees, and the self-employed for hospital insurance under the medicare program are not deductible as medical expenses. However, premiums paid for supplementary medical insurance (part B of the medicare program) are deductible.

In terms of lost Federal revenues, the medical expense deduction is anticipated to cost almost $2.1 billion in fiscal year 1977.

## EXCLUSION OF EMPLOYER-PAID HEALTH INSURANCE PREMIUMS

Section 106 of the Internal Revenue Code excludes from an individual's gross income amounts paid by his employer for the purchase of health insurance for the employee and his family. Although moneys spent in this manner do not count towards income for the employee, they remain fully deductible as a business expense by the employer. It should be noted that neither the exclusion of amounts paid by the employer for health insurance nor the medical expense deduction by the employee for health insurance costs paid by the employee is conditioned upon the health insurance policies purchased meeting any Federal quality standards. The estimated cost in lost Federal revenues for fiscal year 1977 of this exclusion is more than $4.2 billion.

### CHARITABLE DEDUCTIONS PRIMARILY FOR HEALTH CARE

In determining the impact of the Federal income tax on health expenditures it is also necessary to take into account the amount of Federal revenues that are lost as a result of the deductibility of charitable gifts to qualifying health facilities and organizations. Increased use of the tax-exempt form of doing business in the health care field in recent years marks this as an area of potential additional revenue cost in future years. For fiscal year 1977 it is estimated that allowance of such deductions will cost the Government $175 million in lost corporate tax revenues and $830 million in lost individual tax revenues.

The Federal tax treatment of all three types of health-related expenditures leads to additional tax expenditures for health at the State level. This is because most State income taxes are either based on a simple percentage of the Federal tax paid or utilize forms that are mirror images of the Federal collection system. While the State revenue losses are not of the same magnitude as the tax expenditures at the Federal level, the impact of the Federal tax provisions does have the same proportional effect at the State level.

Another feature of tax expenditures for health is that the progressive rate structure embodied in the Federal income tax has the effect of making both exclusions from income and deductions from income worth more to taxpayers in higher income brackets. This effect of the progressive rate structure is somewhat offset in the case of the medical expense deduction, however, by the use of the 3 percent and 1 percent deduction floors on expenses that can be used to offset income.

*Example of calculation of the medical expense deduction.*—A taxpayer has adjusted gross income of $10,000 in 1975. During the taxable year he paid $400 for group health insurance and his employer contributed an additional $400 toward the cost of this insurance. During the year, the taxpayer paid $500 in doctor bills, $100 in hospital bills, and $180 for medicine and drugs. None of these particular expenses were reimbursed by his insurance. His medical expense deduction is computed as follows:

| | |
|---|---|
| Health insurance premiums: | |
| One-half (but not more than $150) premiums paid for health insurance by taxpayer [1] | $150 |
| Medical expenses: | |
| Doctor | 500 |
| Hospital | 100 |
| Health insurance premiums (not deducted above)* | 250 |
| Medicine and drugs | 180 |
| Less 1 percent of $10,000 (adjusted gross income) | −100 |
| Subtotal | 80 |
| 1975 Medical Expenses | 930 |
| Less 3 percent of $10,000 (adjusted gross income) | −300 |
| Subtotal | 630 |
| Allowable deduction for 1975 | 780 |

---

[1] Note that employer's share of health insurance premiums paid is neither included in income or allowable as a deduction by the employee-taxpayer.

# PART V

# Description of Selected National Health Insurance Legislative Proposals

Part V summarizes the principal features of selected national health insurance bills which have been introduced in both Houses of the 94th Congress. Where a bill had a predecessor version in the prior Congress, that fact is noted at the end of each bill summary under the heading, "Major New Features."

## 1. The National Health Care Services Reorganization and Financing Act of 1975 (H.R. 1)

*Date introduced.*—January 14, 1975.
*Chief sponsor.*—Representative Al Ullman.
*Earlier versions.*—92d Congress, H.R. 14140 (Mar. 28, 1972); 93d Congress, H.R. 1 (Jan. 9, 1973).

### A. GENERAL APPROACH

The bill would establish a program of comprehensive health care benefits for all U.S. residents, phased in over a 5-year period, and would provide for creation of Health Care Corporations (HCC's) to cover every geographic area of the country. Employers would be required to provide specified private health insurance for their employees and their families. A federally financed plan would provide health insurance for the aged, low-income, and medically indigent, administered through Federal contracts with insurance carriers. The self-employed and others not eligible for Federal coverage could enroll voluntarily under plans made available by the States at reasonable group rates.

Initially, medicare parts A and B would be merged, the part B premium eliminated, and catastrophic coverage added to the program. These expanded medicare benefits would be extended to low-income groups, to be financed through Federal general revenues. Concurrently, employers would be required to provide their employees with at least this new medicare level of benefits and to contribute at least 75 percent of the premium cost. After the first 4 years of the program, comprehensive health care benefits (CHCB's) broader than the new medicare level, would be mandated for all three plans.

Newly created State health commissions (SHC's) would be responsible for a large part of the program's administration and for setting up health care corporations within each State. HCC's would be community-based, nonprofit organizations capable of providing comprehensive health services to all residents in a given geographic area. The bill would also consolidate all Federal health programs within a new Department of Health and would make available grants, loans, and other incentives to reorganize and improve the delivery of health services.

### B. People Covered

Effective 6 months after enactment of the bill, the aged and low-income would be covered under the combined medicare program. Concurrently, all employers subject to the social security tax (including nonprofit organizations and other employers who have elected social security on a voluntary basis) would be required to provide their employees and dependents with the same level of coverage through private insurance plans. The coverage requirement would not apply to the Federal Government as an employer, but would apply to State and local governments. Three years after enactment, the medically indigent would become eligible for federally contracted coverage.

### C. Scope of Benefits

Initially, the program would cover the level of benefits currently provided under medicare, plus additional catastrophic coverage which would take effect after health expenditures, by or on behalf of an individual or family, reached a specified limit graduated according to income. Medicare deductibles and coinsurance would not be applicable to low-income groups. At the end of the 5-year phase-in period, the following comprehensive health care benefits would be required of the employer-employee plans, the federally contracted coverage for the aged, low-income, and medically-indigent, and the voluntary plans for the self-employed:

*I. Periodic health evaluations*

*a*. Screening tests and exams.

*b*. All immunizations.

*c*. Well-baby care to age 5, with number of covered visits decreasing with age of child.

*d*. Dental services for children to age 7; once child is covered, benefits continue to age 12.

1. One free routine exam per year.
2. Extractions, fillings, etc.—20 percent copayment.

*e*. Vision services for children to age 12.

1. One free routine exam per year.
2. Prescription eyeglasses—20 percent copayment.

*II. Physicians' services and services of other qualified health professionals and allied health personnel*

*a*. Services on outpatient basis in any appropriate setting (including the home) by physician or allied personnel under his supervision—10 visits per year with $2 copay per visit.

*b*. Outpatient disgnostic procedures—20 percent copayment.

*c*. Hospital or outpatient center services.

*d.* Supplies, materials, use of facilities and equipment, including drugs used or administered in connection with outpatient services.

*e.* Ambulance services—20 percent copayment.

### *III. Other outpatient services*

*a.* Outpatient institutional care program for physical disability, mental illness, alcoholism, drug abuse—$2 copayment per day.

*b.* Day car or other part-time services for physical disability, mental illness, alcoholism, drug abuse—3 visits or sessions in lieu of each day of inpatient hospital care allowable during a benefit period.

*c.* Drugs, prosthetic devices, and equipment—$1 copay per prescription, 20 percent copayment for devices and equipment.

*d.* Home health care services—a total of 200 days in any benefit period, with a $2 copay per visit for the following:

1. Intensive home care services, involving coordination by a registered nurse;
2. Intermediate home care services through an affiliated home health agency provider;
3. Basic home health services to individuals requiring "palliative and terminal" care.

### *IV. Inpatient services*

*a.* Hospital care—90 days per benefit period, $5 copayment per day.

*b.* Extended care services—30 days per benefit period, $2.50 copayment per day.

*c.* Nursing home care—90 days per benefit period, $2.50 copayment per day.

*d.* Physicians' services to inpatients—$2 copayment per visit of attending physician only; copayment of 10 percent of charges in cases where a single combined charge is made for services such as surgery, pregnancy, etc.

### *V. Catastrophic expense benefits*

For low-income persons (e.g., individuals with annual income below $2,000, a family of four with income less than $6,000), catastrophic benefits would become effective immediately. For medically indigent persons and all other income classes, benefits would become effective after medical expenses (including amounts paid for premiums, copayments on covered services, etc.) reached a special expenditure limit graduated according to income. For example, a family of four with income of $10,500 would be required to incur $750 in out-of-pocket medical expenses before catastrophic benefits would take effect. Once the expenditure limit is reached, all copayments on covered services would cease, and restrictions on the number of physician visits, hospital stays, etc., would be removed. However, outpatient care for mental illness would be limited to cases in which active medical treatment is provided and psychoanalysis would be excluded except when used for treatment of severe functional disability.

## D. Administration

All Federal health programs would be consolidated within a new Department of Health. The Federal Government would administer the insurance program for the aged and low-income and would contract directly with carriers or HCC's to provide covered benefits. The Federal Government could use the

State as its agent in negotiating contracts. Employer-employee plans would be administered through approved carriers or NCC's. New independent State health commissions (SHC's) would be established in each State to designate geographic service areas for HCC's, authorize incorporation of HCC's, enforce regulations pertaining to providers, control premium rates charged by carriers, HCC's, and nonaffiliated providers, approve charges for institutional and noninstitutional providers of services, approve expansion of health facilities and services, etc. The Department of Health would assume functions of a State health commission in any State which failed to establish one. Private insurance carriers approved by the SHC's would issue qualified insurance policies, collect premiums, administer claims, and reimburse providers in accordance with Federal and State guidelines.

### E. FINANCING

The Federal insurance program for the aged would be financed through payroll taxes and general revenues, with some cost-sharing for services. Government insurance for the poor and medically indigent would be financed through general revenues with some cost-sharing and premium contributions required of the medically indigent. Employers would be required to pay at least 75 percent of the premium cost for employee plans, with employees responsible for the remaining 25 percent. Federal general revenues would also be used to cover the cost of a 10 percent premium subsidy for anyone registering with a health care corporation. Federal tax credits would be made available to employers with less than 10 employees whose required contributions for CHCB's exceeded 4 percent of average wages paid to those employees. Similar tax credits would be available to the self-employed and certain other individuals.

Individual taxpayers would be allowed to deduct 100 percent of the amounts paid by them as premiums for approved CHCB contracts, without regard to the dollar limitation currently applicable under existing Federal income tax law. This amount would be reduced by any amount allowed to self-employed and certain other individuals as a tax credit for such health insurance coverage.

### F. PAYMENTS TO AND STANDARDS FOR PROVIDERS OF SERVICES

State health commissions would be responsible for determining premium rates to be used by private insurers and health care corporations for mandated comprehensive health care benefit packages. SHC's would also approve on a prospective basis all charges for services provided by HCC's and all other health providers, whether or not affiliated with an HCC. State health commissions would review the activities and performance of HCC's and nonaffiliated providers to assure that providers were meeting their obligations under the bill. Federal regulations would prescribe methods to be used in determining reasonable operating costs and sufficient capital payments for HCC's and institutions; and reasonable fees, salaries, or other compensation for individual providers or groups of providers. The Department of Health would also prescribe standards for providers relating to quality, safety, personnel, etc.; as a minimum, providers would be expected to meet existing medicare requirements.

A health card account would be established by an approved carrier for each individual enrolled under the carrier's plan. These accounts would be similar to credit card accounts and would serve as the basis for reimbursement of providers of service. Payments would be made from these accounts by carriers directly to providers of service for covered items and services at the applicable payment rates approved by State health commissions. The provider would be reimbursed the full amount of the approved charge and the carrier would then bill the enrollee for any applicable copayment amounts.

### G. EFFECT ON OTHER GOVERNMENT PROGRAMS

Medicare for the aged would be replaced by the new program. Federal financing of medicaid would eventually be limited to services not covered under the new program. Federal financial assistance under the maternal and child health program would be limited to noncovered services for persons covered by federally contracted insurance.

### H. OTHER MAJOR PROVISIONS

The bill provides that, in accordance with Federally approved State plans, every geographic area within a particular State would be covered by at least one nonprofit health care corporation (HCC), charged with responsibility for making available and furnishing to all residents within the assigned area all the comprehensive health care benefits mandated under the bill. The concept of an HCC would allow for organizational flexibility. The only definitional requirement in the bill is that the organization assure all area residents of CHC benefits. The ownership, organizational form, methods of payment, modes of medical practice, choice of participating providers, etc., would be left to community preference. Initially, health care corporations would develop around existing providers. The bill provides that, as rapidly as possible, HCC's develop a system of outpatient care centers, with empahsis on health maintenance, home care, medical social services, mental health clinics, etc., and undertake a program of continuing health education of HCC registrants. HCC's could be paid on any appropriate prospective or prior-budgeted basis; however, capitation payments would be encouraged through the use of financial incentives to consumers who register with HCC's and would be mandated as an option after the first 5 years of operation of the HCC. Federal grants and contracts would be available to facilitate the planning, organizing, developing, and establishing of HCC's. Federal grants would also be authorized for (1) State health commissions to cover all or part of the necessary cost of developing and preparing State health plans, and (2) development and initial operation of home health care agencies.

### MAJOR NEW FEATURES

1. The reimbursement provisions have been amended to establish a *health card* system (similar to the health credit card provision contained in H.R. 12684—the administration's bill in the 93d Congress). Carriers would be required to establish a credit account for each individual enrolled with them. Payments would be made by carriers from these accounts directly to the providers of services for the full amount of the charge prospectively approved by the State health commissions. Carriers would then bill the enrollee for any applicable copayment amount. This system would apply both to HCC's and non-HCC providers.

2. The term "health-related custodial care" has been changed to "*palliative and terminal care.*"

3. The new bill includes a statement of congressional findings that *philanthropic support* for health care should be continued and that nothing in the bill is intended to eliminate or limit such support.

4. The definition of the term "State" has been expanded to include the *Virgin Islands* and *Guam.*

5. The new bill includes *State and local governments* under the definition of "employer" for purposes of the program. However, Federal Government employees would still remain outside the program. (Under the previous bill, the term "employer" was not applied to Federal, State, or local governments.)

6. The previous bill had contained a Federal subsidy feature for small employers whose costs for required CHCB coverage for employees exceeded 4 percent of wages. This feature has been eliminated and replaced with a *tax credit for employers* with 10 or fewer employees, whose premium costs exceed 4 percent of wages paid to those employees. A similar tax credit provision would be available to the self-employed and certain other individuals.

7. Benefits for outpatient services have been expanded to include "outpatient institutional care *programs for physical disability*" and "day care or other part-time services for rehabilitation of the physically disabled" on the same basis and subject to the same terms and cost-sharing applicable to such programs for treatment of mental illness, alcoholism, and drug abuse.

8. The term "ancillary health care" (as included in the benefit structure under covered physicians' services) has been changed to "services of *other qualified health professionals* and allied health personnel."

9. The previous bill had limited inpatient hospital care for *treatment of mental illness* to a period of 45 days, with 90 days allowed to enrollees of a health care corporation. The new bill omits this special limitation, thereby allowing 90 days of hospital care regardless of the mental or physical condition and irrespective of enrollment with an HCC. However, inpatient treatment of mental illness would only be covered if the patient were in an acute phase and subject to "active medical treatment," as defined in item 13.

10. The new bill provides that expenses incurred for *outpatient treatment of physical disability* could be included among the amounts applied toward satisfaction of the special expenditure limit applicable to catastrophic benefits.

11. The old bill had excluded expenses for inpatient or outpatient *treatment of mental illness* from those expenses which could be credited toward satisfaction of the catastrophic deductible. The new bill omits this provision.

12. The new bill provides that outpatient care for *mental illness,* when provided as part of catastrophic expense benefits, must be characterized by "active medical treatment," as defined in item 13.

13. The term "*active medical treatment,*" for purposes of both inpatient and outpatient treatment of mental illness, means a "written and individualized plan that is based on diagnoses; based on goals relative to arrest, reversal, or amelioration of the disease process or illness and aimed at restoring the individual's adaptive capacity to the maximum extent possible; based on objectives relating to such goals; comprised of defined services and activities; specific as to the means to measure the progress or outcome; and clear as to periodic review and revision of the plan.

14. The new bill directs the Secretary of Health, in considering regulations pertaining to the definition of services to be included under outpatient institutional care programs for the physically disabled, to give consideration to inclusion of *appropriate transportation services*.

15. The new bill describes extensively the three different concentrations of home health care services covered under the program. The old bill had contained a more narrow definition of such services. The new definition would include——

*a. Intensive home care services*, involving the professional coordination of a registered nurse, including:

1. Part-time or intermittent nursing care;
2. Physical, respiratory, occupational or speech therapy;
3. Medical social services;
4. Services of a home health aide, in accordance with regulations;
5. Diagnostic and therapeutic items or services, furnished by a hospital or outpatient center;
6. Drugs, medical supplies, appliances, and equipment;
7. Hospital or outpatient center physicians' services;
8. Medical services of an intern or resident provided in patient's home or hospital outpatient center; and
9. Ambulance or other special transportation services to and from the patient's home and the provider institution, when indicated by the patient's condition and when involving the use of equipment which cannot be made available in the patient's home.

*b. Intermediate home health care services*, provided either directly or through an affiliated home health agency, including:

1. Part-time or intermittent nursing care;
2. Physical, occupational, or speech therapy;
3. Medical social services;
4. Services of a home health aide, as permitted in regulations;
5. Medical supplies (other than drugs) and use of medical appliances and equipment;
6. Medical services of an intern or resident in an affiliated home health agency provider; and
7. Any of the foregoing items or services provided on an outpatient basis, under arrangements made by an HCC or home health agency, at a hospital, skilled nursing facility, or rehabilitation center, and which involve the use of equipment which cannot be made readily available in the patient's home; transportation would not be included except for ambulance service when other transportation is contraindicated by the patient's condition.

*c. Basic home health services*, furnished either directly or through an affiliated home health agency to persons requiring "palliative and terminal care," as follows:

1. Part-time or intermittent nursing;
2. Medical social services including counseling;
3. Part-time or intermittent home health aid services, assigned and supervised by a registered nurse; and
4. Medical supplies (other than drugs) and use of medical appliances and equipment.

16. The new bill authorizes the Secretary to prescribe standards for *systems of accounting* that can provide guidance to State health commissions in developing such systems adapted to individual State needs and also to set standards for a *national system of reporting and billing.*

17. In determining *financial requirements of health care corporations* and other providers, the new bill authorizes the Secretary to consider provisions to assure that gifts, grants, loans, endowments, etc., will not be deducted from operating costs when computing reimburseable costs unless (1) such amounts are designated for specific operating costs, (2) such amounts were not restricted as to use and are commingled with other funds, in which case the income derived from investment of such funds may be deducted from interest expense when computing reimbursable costs. The Secretary must also assure that gifts, etc., are not utilized for facilities which have not been granted a certificate of need.

18. The new bill expands the grant authority of the Secretary to include grants to health care corporations, or public or nonprofit providers affiliated with an HCC, for the initial operation of new or *expanded home health care agencies.*

19. The new bill broadens the requirements for approval of a State health plan to include a requirement that the State develop and implement, consistent with the Secretary's regulations, *a system of uniform accounting,* reporting, and billing to be utilized by providers, carriers, and the State health commission within that State.

20. The new bill contains a description of the methods which may be used by State health commissions for purposes of *prospective reimbursement* of providers, including budget review, negotiated rates, target rates, formulas, and others.

21. The new bill provides that rates of providers prospectively approved would be applicable to a "particular fiscal period," rather than the "12-month period" specified in the old bill.

## 2. The Health Security Act of 1975 (H.R. 21; S. 3)

*Date introduced.*—January 14, 1975.

*Chief sponsors.*—Representative James C. Corman and Senator Edward M. Kennedy.

*Earlier versions.*—91st Congress, S. 4297 (Aug. 27, 1970); 92d Congress, S. 3 (Jan. 25, 1971), H.R. 22 (Jan. 22, 1971); 93d Congress, S. 3 (Jan. 4, 1973), H.R. 22 (Jan. 4, 1973).

### A. General Approach

The proposal would provide for the establishment of a national health insurance program covering the entire population and offering a broad and comprehensive range of services. For covered services there would be no cutoff dates, no coinsurance, no deductibles, and no waiting periods. The program would be financed by a Federal payroll tax on employers and employees, a tax on unearned income and self-employment earnings, and by Federal general revenues. The bill would create an administrative structure within the Department of Health, Education, and Welfare to be charged with the administration of the program. The proposal includes provisions which are intended, through study and evaluation as well as through economic incentives and grants and loans, to reorganize and improve the delivery of health care services, to alleviate shortages and maldistribution of health personnel and facilities, and for the development of community home care programs designed to maintain chronically ill or disabled persons in their own homes, in lieu of institutional care.

## B. People Covered

All residents of the United States would be eligible for benefits, including aliens admitted as permanent residents or for employment. No history of contributions to the program would be required. The bill would allow for reciprocal and "buy-in" agreements to cover certain nonresident aliens and in some cases, U.S. residents traveling abroad.

## C. Scope of Benefits

A comprehensive range of health services would be covered under the program, with no payment required of the patient for those services covered in full and without limitation. Limitations would be applied primarily in the area of psychiatric care, nursing home care, dental services, and prescription drugs, as noted in the following list of covered services:

### *Institutional services*

General hospital inpatient and outpatient care, including pathology and radiology services.

Psychiatric care in a general or psychiatric hospital—limited to 45 consecutive days of active treatment during a benefit period.

Skilled nursing home care—restricted to 120 days per benefit period. Period may be extended, however, for (1) nursing homes owned or managed by a hospital if payment for care is made through the hospital's budget, and for (2) all homes depending on the availability of funds.

Ambulance services, by regulation.

### *Practitioner services*

Physicians' services (nonpsychiatric): includes physical checkups, immunizations, well-child care, and family planning services.

Physicians' psychiatric services—limited to 20 visits during a benefit period, except when benefits are provided through group practice organizations, hospital outpatient departments, or comprehensive mental health care organizations, in which case there is no limitation.

Dental services—exclusive of most orthodontia and restricted at the program's inception to children under the age of 15, with the covered age group extended annually by two years until all those under age 25 are covered. However, the Health Security Board is authorized to expand dental benefits more rapidly if availability of resources permit. Within 7 years of the effective date of the legislation, the Board would be required to establish a timetable for phasing in dental benefits to the entire population.

Optometrists and podiatrists services.

### *Other services*

Home health agency services.

Diagnostic services of independent pathology laboratories, and diagnostic and therapeutic radiology furnished by independent radiology services.

Care of a psychiatric patient in a mental health day care service—covered for up to 60 days.

Services of free-standing ambulatory drug abuse and alcoholism centers, family planning centers, and rehabilitation centers.

Supporting services—psychological, physiotherapy, nutrition, social work, and health education are covered services if they are part of institutional services or are furnished by a group practice organization, individual practice association, or certain public or non-profit agencies.

Prescription drugs—limited to those provided through hospital inpatient or outpatient department, through skilled nursing homes, or through organized patient care programs, such as group practice organizations and individual practice associations. For other patients, coverage would extend only to drugs from an approved list, as required for specified chronic illnesses or conditions requiring prolonged or costly drug therapy.

Medical appliances—therapeutic devices, appliances, and equipment (including eyeglasses, hearing aids, and prosthetic appliances) from an approved list. Expenditures to be limited to 2 percent of total program expenditures if possible.

### D. Administration

At the Federal level, the program would be administered within the Department of Health, Education, and Welfare. A five-member Health Security Board, appointed by the President with the consent of the Senate, would be responsible for general administration of the program, including policy and regulation, control of expenditures, standards and reimbursement for providers of services, initiation of studies as to the adequacy of the financing of the program, quality, and costs of services, etc. An Executive Director would serve as Secretary to the Board and chief administrative officer of the program.

A National Health Security Advisory Council would assist the Board by advising on policy and evaluating operation of the program. The Council would include the Chairman of the Health Security Board and 20 additional members, including representatives of consumers (who would constitute a majority) and providers of health services.

A Commission on the Quality of Health Care would be established in the Department to recommend to the Secretary and to the Board standards pertaining to the quality of health care provided under the program. The Commission would consist of seven representatives of providers of health services or of nongovernmental organizations engaged in development standards for health care, and four representatives of consumers of health care. The Commission would be responsible for monitoring providers for compliance with established standards of care.

HEW regional offices and local health service area offices would be responsible for administering the program at their respective levels. Regional and local advisory councils, similar in composition to the National Advisory Council, would advise the regional and local offices. Individuals or providers with grievances would be entitled to hearings, appeals, and judical review in Federal courts.

No private health insurance organizations would be used under the plan.

## E. FINANCING

The program would be financed through a Health Security Trust Fund. Income to the fund would be derived from the following sources:

1. A 3.5 percent tax on employers' payrolls;
2. A 1 percent tax on employees' wages up to $20,000 a year;
3. A 2.5 percent tax on self-employed income and on unearned income up to $20,000 a year;
4. Contributions from Federal general revenues equal to the total amount collected through health security taxes.

Persons over age 60 would be allowed to exempt the first $5,000 in unearned income from the 2.5 percent health security tax. The Internal Revenue Code would be amended to disallow income tax deductions for medical care covered by the program.

Through collective bargaining, employers could agree to pay part or all of their employees' required contribution. Employers would not be relieved by enactment of the program of any existing contractual or other nonstatutory obligation to provide or pay for health services to present or former employees. If an employer's existing obligations for the purchase of health benefits for his employees are greater than 3.5 percent of payroll, the excess would be applied toward the 1 percent which would otherwise be withheld from an employee's wages.

## F. PAYMENTS TO AND STANDARDS FOR PROVIDERS OF SERVICES

Each year, a national health budget for the coming year would be established. The budget could not exceed the estimated total receipts for that year from health security taxes and general revenues but could be modified if later estimates of program experience indicated that tax receipts or expenditures differed significantly from the estimates or if an epidemic or similar event required higher expenditures.

Funds would be allocated by the Board to each region on a per capita basis for institutions, physicians' services, dental services, drugs, appliances, and other professional and miscellaneous services. Regional funds would be further allocated on a similar per capita basis to the local health service areas. Authorization is provided to eliminate unwarranted differences in average costs of health services among the regions by curtailing increases in funds to high expenditure regions and increasing the availability of services in low expenditure regions.

Providers of health services would be compensated directly by the Health Security Board; individuals would not be charged for covered services. Hospitals, nursing homes, and home health agencies would be paid on the basis of approved prospective budgets designed to pay reasonable costs. Independent practitioners such as physicians, dentists, podiatrists, and optometrists could elect to be paid by various methods, including fee-for-service, capitation, salary, and supplemental stipends for practitioners locating in remote or medically-deprived areas. A medical or professional society could administer the fee-for-service reimbursement on the basis of fee schedules or relative value scales prescribed by regulation.

Group practice organizations and individual practice associations would be paid a basic capitation rate multiplied by the number of eligible enrollees;

these organizations could then reimburse affiliated providers of services by methods which they chose to arrange among themselves. A group practice organization or individual practice association would be entitled to share in up to 75 percent of any savings which are achieved by reduced utilization of institutional services by its enrollees—provided (1) that the Board finds that the services furnished have been of high quality and adequate to the needs of its enrollees; and (2) that the average utilization of hospital or skilled nursing services by the enrollees is less than the use of such services by comparable population groups not so enrolled.

The bill includes various provisions designed to ensure the quality of health care provided under the program. National standards for participation by providers of services would be established similar to those required under medicare, but more exacting. At the start of the program, independent practitioners would be eligible to participate if they were licensed in at least one State and met the program's requirements for continuing education. For practitioners licensed after the start of the program, new national standards established by the Board would also apply. A State-licensed practitioner who met national standards would be considered qualified to provide services in any other State. Nurses and other health professionals would also be required to meet national standards (including a requirement for licensure in at least one State). Major surgery and certain other specialist care would be covered only when furnished by qualified specialists and generallly only upon referral from a primary care practitioner.

Hospitals and other institutions would be eligible to participate if they meet national standards and if they establish utilization review and affiliation arrangements. Special conditions of participation would apply to group practice organizations and individual practice associations.

## G. Effect on Other Government Programs

Medicare would be terminated and the assets and liability of both medicare trust funds would be transferred to the health security fund. Federal aid to the States for medicaid and other Federal programs, such as vocational rehabilitation and maternal and child health, would also cease, except to the extent that benefits under such programs are broader than under the health security program. The bill does not affect current provisions for personal health services under the Veterans Administration, temporary disability or workmen's compensation programs, the Department of Defense, or institutions of HEW serving merchant seamen, Indians and Alaskan Natives. The bill does, however, provide for a study of methods of coordinating HEW and veterans programs with the proposed plan.

## H. Other Major Provisions

Financial, professional, and other incentives are provided in order to stimulate the establishment of group practice organizations; to encourage the training continuing education, and effective utilization of health personnel, particularly those in short supply; to encourage linkages between physicians and specialists and other patient-care resources such as health institutions; and to develop new community-based home health care programs designed to maintain chronically ill or disabled persons in their own homes, in lieu of institutional care. A special resources development fund would be established to commence operation for the period between enactment and when health security benefits began, in order to prepare the system for the anticipated greater demands to be placed upon health facilities and providers.

## MAJOR NEW FEATURES

1. *Catastrophic protection* is specifically recognized in the preamble of the bill.

2. The terms "*group practice organization*" and "*individual practice association*" have been substituted in all references to what had previously been termed "health maintenance organization" and "professional foundation."

3. Professional services of *optometrists* have been delineated to include "examination, diagnosis, and treatment of conditions of the vision system."

4. *Optometrists and podiatrists* have been defined as "physicians" when furnishing certain covered services under the program.

5. *Free-standing* ambulatory alcoholism and drug abuse centers, free-standing family planning centers, and free-standing rehabilitation centers would be recognized as providers of services.

6. An amendment on *employment rights* (including collective bargaining) in health institutions is incorporated into the new bill.

7. The Internal Revenue Code would be amended to disallow *income tax deductions* for medical services covered by the health security program.

8. The *exemption* from health security taxes of the first $3,000 in unearned income for persons over age 60 has been *raised to $5,000.*

9. The *ceiling* on payroll and individual taxes for the health security program has been *raised from $15,000 to $20,000* (or 150 percent of the social security wage base).

10. The new bill establishes a Federal grant program for development of community programs designed to maintain disabled or chronically ill persons in their own homes, in lieu of institutional care. *Personal care services* included in such a program could include homemaker and home help services, home maintenance, laundry services, meals-on-wheels, and other nutrition services, assistance with transportation and shopping, etc. (The old bill provided grants for "conducting tests and demonstrations into the feasibility" of such home care programs.)

11. New provisions authorize the Secretary to *establish a staff* of up to 50 positions for the Health Security Board and up to 25 positions for the Commission on the Quality of Health Care.

12. The planning, resource development, and administration sections of the new bill have been revised to coordinate with provisions of the recently enacted *title XV of the Public Health Service Act* (Public Law 93–641—the National Health Planning and Resources Development Act of 1974).

## 3. The National Health Insurance Act (H.R. 94)

*Date introduced.*—January 14, 1975.
*Chief sponsor.*—Representative John Dingell.
*Earlier versions.*—90th Congress, H.R. 12741 (August 31, 1967); 91st Congress, H.R. 24 (January 3, 1969); 92d Congress, H.R. 48 (January 22, 1971); 93d Congress, H.R. 33 (January 3, 1973).

### A. GENERAL APPROACH

The proposal would establish a national health insurance program covering almost all residents of the United States. Standard benefits are broad and they would be financed through payroll taxes and Federal-State general revenues. The program would be administered by the Federal Government but would be decentralized with major administrative responsibilities placed at the State and local level. The bill contains provisions designed to improve the supply, quality, and distribution of health manpower and facilities.

### B. PEOPLE COVERED

Virtually all U.S. residents would be covered. Almost all employees and self-employed persons would be covered and all persons eligible for social security benefits would be protected. Funds appropriated for various Federal-State health care programs could be used to obtain coverage for recipients of public assistance and the unemployed.

### C. SCOPE OF BENEFITS

The proposal permits broad medical benefits but, in implementing the program, benefits would be made available in accordance with a State plan. The standard benefits available without limit, except as indicated, are as follows:

*Institutional services*

General hospital inpatient care: 60 days. Psychiatric and tuberculosis hospital care: 30 days; length of stay can be extended by regulation if funding and facilities are adequate. Hospital outpatient care.

*Personal services*

Physicians' services. Dentists' services. Physical checkups; periodic medical and dental examinations. Home health services. Podiatrists' services. Optometrists' services and eyeglasses. Laboratory and X-rays. Physical therapy and related services.

*Other services and supplies*

Medical appliances. Prescription drugs: types of drugs which are unusually expensive.

If the national health insurance board in consultation with the national advisory medical policy council (both created by this bill) finds that available resources are inadequate to provide dental, home health, or certain other specified services, it may limit these services for a period. In the case of dental services, priority would be given to children.

## D. ADMINISTRATION

The program would be administered at three levels of government—Federal, State, and local—with the major operating responsibility falling to the State and local jurisdictions. Each State would evaluate its health resources and capabilities and, in accordance with national guidelines, would develop a health care plan. The State plans would be submitted to the national health insurance board and, when approved, the board would contract with the State for the administration of the program within that State.

### *Federal level*

A National Health Insurance Board with five members would be established in the Department of Health, Education, and Welfare. Three members would be appointed by the President to serve with the Surgeon General and the Commissioner of Social Security. The Board would establish the regulations and standards for the program, supervise the State and allocate funds. If the Board finds that a State is not complying with the provisions of its plan, the Board can administer the program in that State.

A National Advisory Medical Policy Council would be established consisting of the Chairman of the national board and 16 members appointed by the Secretary of Health, Education, and Welfare. At least eight members would serve as consumer representatives and at least six as representatives of providers of medical services. The Advisory Council would advise the Board on matters of general policy and administration, establishment of professional standards, and other matters.

### *State and local levels*

The administrative agency in each State would, if possible, be the same agency that administers its public health material and child health programs. State plans would:

1. Provide for a State advisory committee with a majority of members representing consumers and the remaining members representing providers;
2. Establish local health-service areas and provide methods for selecting their advisory committees;
3. Provide for surveys of resources and needs of the State;
4. Give assurance that maximum use would be made of available health personnel and facilities and that funds would be allocated to local areas in such a way as to correct maldistributions and inadequacies.

Local area agencies, with the assistance of a similar advisory council representing consumers and providers, would administer the program at the local level, make payment to providers, and carry out related administrative duties.

## E. FINANCING

A personal health service account would be established to hold the funds of the national program. The account would receive an amount equal to 3 percent of total earnings. (The definition of earnings would be the same as under the social security law.) In addition, for the specific purpose of financing the cost of dental, home health, and certain other services, the account would receive an additional amount equal to one-half of 1 percent in the first year of the program.

This additional amount would increase to an ultimate rate of 1 percent in the third year. Further, in the first year of the program, an additional 1 percent of earnings would be appropriated as a reserve and the bill authorizes any additional funds required to meet expenditures. While the bill does not specify the source of any of these funds, the apparent intent is that they be obtained from a payroll tax on employers and employees covered under social security.

## F. Payments to and Standards for Providers of Services

The National Board would allocate funds among the States for each of five classes of health services (medical, dental, hospital, home health, and auxiliary) on the basis of population, availability of health resources and the costs of services, as indicated in the State plan. The allocation would be designed to assure that adequate health benefits are provided in all States and to improve the adequacy of services where they are below the national average.

The State agencies would contract with providers of care for services under the program and determine rates of payments. The payments could be administered by the State agency or the local health-service area. Nonprofit health-service insurance plans could be used as agents or intermediaries.

Hospitals and other institutions would be reimbursed on the basis of reasonable costs. In calculating costs, the payment for room and board would be based on the least expensive multiple-bed accommodations. A maximum rate for hospitalization could be established (after consultation with representatives of provider organizations) and it could vary according to locality and class of service.

Physicians and dentists could select reimbursement under various methods, including fee-for-service (based on a fee schedule), capitation (with maximum limits on the number of registered patients), full- or part-time salary, or a combination of these methods. Specialists could choose the same methods and, in addition, payment on a per session or per case basis.

Rates of payment would be geared to local conditions. In deriving the rates of payment under the various methods, consideration would be given to the annual income that would accrue to practitioners. Further, reimbursement would be designed to provide incentives to practitioners to advance in their professions, pursue postgraduate studies, maintain high-quality service, allow for adequate vacation, and practice in areas where their services are needed.

Standards of participation for providers of services under the program would include the following:

### *Hospitals and institutions*

Hospitals or institutions qualified under States standards could participate in the program. If a State has not established standards, the National Board would establish them for the State.

### *Professional practitioners*

Physicians, dentists, and podiatrists legally authorized to practice in a State would qualify. Specialists would be required to meet standards established by regulation.

### *Nurses*

Professional nurses registered in the State would qualify. Practical nurses qualified under State standards or standards established by regulation could provide home health service.

### G. EFFECT ON OTHER GOVERNMENT PROGRAMS

Initially, aged persons could receive those benefits of the program not provided under medicare. The Department of Health, Education, and Welfare would be required to study the relationship between the national health insurance plan and the medicare program and devise methods of incorporating medicare into the national plan. Funds appropriated for medicaid and other Federal-State assistance programs could be used by States to finance the cost of covering needy persons who do not make regular contributions required by the program.

### H. OTHER MAJOR PROVISIONS

The National Health Insurance Board, after consultation with the National Advisory Council and other Federal agencies, is authorized to make grants-in-aid for training and education to students and educational institutions. To finance this program, $10 million would be available for the first year of the program, $15 million for the second, and for each following year an amount equal to one-half of 1 percent of benefit expenditures in the previous year.

## 4. The National Catastrophic Illness Protection Act of 1975 (H.R. 1373)

*Date introduced.*—January 14, 1975.

*Chief sponsor.*—Representative Robert A. Roe.

*Earlier versions.*—91st Congress, H.R. 18008 (June 10, 1970), S. 4031 (June 26, 1970); 92d Congress, H.R. 817 (Jan. 25, 1971), S. 191 (Jan. 26, 1971); 93d Congress, H.R. 1054 (Jan. 3, 1973), S. 587 (Jan. 29, 1973).

### A. GENERAL APPROACH

The proposal is designed to encourage the development by the private insurance industry of policies which provide individuals with extended coverage against the costs of catastrophic illness. Individuals could purchase on a voluntary basis private insurance policies that would pay for medical expenses after such expenses exceeded a specified amount, depending on family income and size. Each State would design its own health insurance plan in accordance with HEW regulations. HEW would determine the actuarial value of the catastrophic insurance policy in each State and establish premium rates which might be lower than the actuarial value, if such lower rates resulted in more widespread coverage. Federally financed "premium equalization payments" would be paid to insurance carriers to make up the difference between the actuarial value and the established premium for catastrophic coverage. The Federal Government would also reinsure against losses in instances where private insurance carriers paid out more in benefits than they received in premiums.

### B. PEOPLE COVERED

All persons would be entitled to enroll on a voluntary basis.

## C. SCOPE OF BENEFITS

Under this proposal, a catastrophic plan offered by private insurers would be designed to cover costs of medical care rather than specified benefits. Any services defined as medical care under the present Federal income tax law relating to medical expense deductions could be included in a State insurance plan. Before payments would be made under a catastrophic plan, a sliding deductible based on adjusted income of an individual or family would have to be satisfied. The "adjusted income" is "adjusted gross income" shown on the Federal income tax return reduced by the total amount of personal exemptions ($750 per person effective for 1973). The deductible would be equal to one-half of the amount by which the individual's or family's adjusted income exceeds $1,000 but does not exceed $2,000, plus all of the amount by which such adjusted income exceeds $2,000. For example, an individual with an adjusted gross income of $10,000 and an "adjusted income" (after the $750 personal exemption) of $9,250, would have an annual deductible of $7,570. A family of four with the same income would have a deductible of $5,500. The deductible would be reduced by the amount of any out-of-pocket payments or any public or private third party payment made on behalf of an insured person, including expenses paid through medicare, medicaid, etc.

## D. ADMINISTRATION

Each State would be responsible for designing its own health insurance plan. HEW would administer a plan in any State that did not establish one. State insurance departments would supervise private carriers who would in turn sell the insurance, collect premiums, and administer claims. Insurance departments would also arrange for pooling of risks among private insurers within a State. The Federal Government's role would be mainly limited to contracting with private insurers for reinsurance coverage. An insurance carrier would pay the Government certain premiums or fees for reinsurance. HEW would also set premium rates to be used by private insurers for catastrophic plans.

## E. FINANCING

Castastrophic insurance would be financed by means of payments of premiums to private insurers. If HEW established a premium rate lower than the actuarial value of the catastrophic plan, the Federal Government would pay carriers the difference between the actuarial value and the established premium. These "premium equalization payments" would be financed through Federal general revenues through a special national catastrophic illness fund. The Government's reinsurance program would be financed through premiums paid by private insurers into the fund.

## F. PAYMENTS TO AND STANDARDS FOR PROVIDERS OF SERVICES

No provision.

## G. EFFECT ON OTHER GOVERNMENT PROGRAMS

Medicaid and other assistance programs would no longer pay for services covered by the catastrophic insurance plans.

## 5. The National Comprehensive Health Benefits Act of 1975 (H.R. 2050)

*Date introduced.*—January 23, 1975.
*Chief sponsor.*—Representative Harley Staggers.
*Earlier version.*—H.R. 11345 (Nov. 8, 1973).

### A. GENERAL APPROACH

The bill would establish a program of comprehensive health care benefits for all U.S. residents, phased in over a 6-year period. Financing would be primarily through employer (75 percent) and employee (25 percent) contributions to the costs of purchasing private health insurance providing the defined benefits, and secondarily through Federal general revenues to meet the costs of coverage for the aged, poor, unemployed and near poor.

Newly created State health commissions (SHC's) would be responsible for the actual administration of much of the program, including standard setting and quality control, assisting in the development of health maintenance organizations (HMO's), and administration of some of the insurance provisions. Existing private health insurance carriers would be used to underwrite most of the legislation's insurance benefits. The development and use of HMO's would be encouraged through additional direct developmental assistance and through a 10 percent Federal subsidy of HMO premiums.

### B. PEOPLE COVERED

Within 2 years of enactment all aged, low-income, and unemployed individuals and families would be provided coverage for basic health services. Within 4 years of enactment all individuals and families would be provided coverage for basic health services and the costs of catastrophic illness. Within 7 years of enactment all individuals and families would be provided coverage for comprehensive health care benefits and the costs of catastrophic illness.

### C. SCOPE OF BENEFITS

Basic health services are similar to those which HMO's would be required to provide under HMO developmental legislation. They include (as specified by the Secretary of HEW in regulations):

1. Physician services.
2. Hospital services.
3. Laboratory and radiologic services.
4. Limited, acute mental health services.
5. Home health services, and
6. Preventive health services.

Comprehensive health care benefits include:

*I. Periodic health evaluations*

*a.* Screening tests and exams.

*b.* All immunizations.

*c.* Well-baby care to age 5, with number of covered visits decreasing with age of child.

*d.* Dental services for children to age 12.
  1. One free routine exam per year.
  2. Extractions, fillings, etc.—20 percent copayment.

*e.* Vision services for children to age 15.
  1. One free routine exam per year.
  2. Prescription eyeglasses—20 percent copayment.

*II. Physicians' services and ancillary health care*

*a.* Services on an ambulatory basis in any appropriate setting (including the home) by physician or allied personnel under his supervision—50 visits per year with $3 copay per visit.

*b.* Ambulatory diagnostic procedures—20 percent copay.

*c.* Hospital or ambulatory center services.

*d.* Supplies, materials, use of facilities and equipment, including drugs used or administered in connection with outpatient services.

*e.* Ambulance services—20 percent copay.

*f.* Voluntary family planning and infertility services.

*III. Other ambulatory services*

*a.* Ambulatory institutional care program for mental illness, alcoholism, drug abuse—$2 copay per day, limited to 120 visits per coverage year.

*b.* Drugs, prosthetic devices, and equipment—$1 copay per prescription, 20 percent copay for devices and equipment.

*c.* Home health services—100 visits with $2 copay per visit.

*IV. Inpatient services*

*a.* Hospital care—60 days per 90 day benefit period, except for mental illness, alcoholism, drug abuse where limit is 45 days. Copay $5 per day.

*b.* Extended care services—30 days per benefit period with $2.50 copay per day.

*c.* Nursing home care—60 days per benefit period with $2.50 per day copay.

*d.* Physicians' services to inpatients—$3 copay per visit of attending physician only.

Catastrophic expense benefits would provide that, once an expenditure limit in any given year was reached, all copayments for services, limits on the number of services covered, and other restrictions and limits no longer applied and that coverage was complete. These benefits would become effective immediately for low-income persons (individuals with annual income below $2,500; a family of 4 with income under $6,500). For all others the benefits would become effective when medical expenses reached a special expenditure limit graduated according to income. For example, a family of four with income of $10,500 would be required to incur $1,000 in out-of-pocket expenses before the benefits took effect.

## D. ADMINISTRATION

The Federal Government would administer the insurance program for the aged and low-income and would contract directly with carriers or HMO's to provide covered benefits. Employer-employee plans would be administered through approved carriers or HMO's. New independent State health commissions (SHC's) would be established in each State to authorize incorporation of HMO's, enforce regulations pertaining to providers, approve expansion of health facilities and services, etc. The Department of HEW would assume functions of a State health commission in any State which failed to establish one.

Private insurance carriers would issue qualified insurance policies, collect premiums, administer claims, and reimburse providers in accordance with Federal and State guidelines.

## E. FINANCING

The Federal insurance program for the aged, poor, and near poor would be financed through general revenues with cost-sharing for services and premium contributions scaled according to financial means. Employers would be required to pay at least 75 percent of the premium cost for employee plans, with employees responsible for the remaining 25 percent. Federal general revenues would also be used to cover the cost of a 10 percent premium subsidy for anyone enrolled with an HMO.

## F. PAYMENTS TO AND STANDARDS FOR PROVIDERS OF SERVICES

State health commissions would be responsible for determining premium rates to be used by private insurers and/or HMO's for mandated comprehensive health care benefit packages. SHC's would also approve on a prospective basis all charges for services provided by HMO's and all other health care providers. State health commissions would review the activities and performance of HMO's and health care providers to assure that providers were meeting their obligations under the bill. Federal regulations would prescribe methods to be used in determining reasonable operating costs and sufficient capital payments for HMO's and health service institutions; and reasonable fees, salaries, or other compensation for individual providers or groups of providers. The Department of HEW would also prescribe standards for providers relating to quality, safety, personnel, etc.; as a minimum, providers would be expected to meet existing medicare requirements.

Non-HMO providers would be reimbursed by private carriers underwriting the comprehensive health care benefits plan. HMO's would be paid directly by enrollees or by carriers contracting with them on any appropriate prospective or prior-budgeted basis (including capitation or itemized charges for specific services). After the first 5 years of operation, an HMO would be required to provide a complete prepayment option to enrollees.

## G. EFFECT ON OTHER GOVERNMENT PROGRAMS

No other Government program would be immediately or directly affected. Both medicare and medicaid would continue in effect. However, since the proposed program would, when fully operational, provide all people with benefits broader than are currently available under these and other programs, they would eventually need modification to assure that they supplement the proposed program. Provision for this is included in the case of medicaid.

## H. OTHER MAJOR PROVISIONS

The legislation contains a variety of other provisions designed to assure an open, flexible program which will serve the needs of both consumers and providers. These include:

1. Creation of a new National Health Services Advisory Council whose responsibilities include review and comment upon proposed new or revised regulations under the bill prior to their publication in Federal Register.

2. An emphasis upon health education and an individual's responsibility for both the maintenance of his own health and proper utilization of available health services.

3. A requirement that the Advisory Council conduct a study of methods for providing health care institutions with appropriate capital funding (particularly in needy areas).

4. Provision that persons who are defined as low-income or medically indigent and are covered under an employer plan for comprehensive health care benefits, would be entitled to a premium contribution refund, if the amount of their contribution under the employer plan exceeded the amount they would contribute under the federally financed plan for such persons.

5. Authority for the Secretary to regulate the retention of premium income in excess of payments as benefits by private carriers.

6. Provisions to protect the confidentiality of information gathered under the program concerning individuals and to assure public access to all fiscal and other information concerning the program's operation.

7. A requirement that all carriers offering plans under the program make full disclosure to covered individuals, upon request, of available benefits, exclusions from coverage, premium rates, terms and conditions of available options for enrolling in HMO's, and the percentage of premiums paid out as benefits.

8. A requirement that States make possible citizen actions to compel either SHC's or carriers to comply with the requirements of the program.

9. Requiring carriers, HMO's, and other providers of health care to make information available to individuals concerning their charges, hours of operation, and licensure.

10. A provision requiring SHC's to regulate the retention rate and promotion of all health insurance offered for purposes of complementing or supplementing insurance providing comprehensive health care benefits.

### MAJOR NEW FEATURES

Technical revisions to make the new bill conform to the provisions of the recently enacted title XV of the Public Health Service Act (Public Law 93–641—the National Health Planning and Resources Development Act of 1974).

## 6. Medical Expense Tax Credit Act of 1975 (H.R. 3328; S. 600)

*Dates introduced.*—February 19, 1975; February 7, 1975.

*Chief sponsors.*—Representative James Martin, Senator William Brock.

*Earlier versions.*—93d Congress, S. 3670 (June 19, 1974).

### A. GENERAL APPROACH

The bill would provide for a system of protection against the costs of catastrophic illness by means of refundable tax credits for excessive medical expenses. The proposal would allow persons to claim as credits against personal income taxes amounts equal to 85 percent of an amount by which medical care expenses, paid or incurred, exceed 15 percent of "modified adjusted gross income," as defined in the bill. The tax credit would ordinarily be claimed on the regular income tax return.

## B. People Covered

All individuals and families potentially subject to the income tax, or virtually the entire population, could file for tax credits under the proposal. Persons whose only support is from nontaxable income, e.g., social security payments, disability payments, AFDC, welfare payments, etc., would be eligible for refundable tax credits upon application.

## C. Scope of Benefits

A credit against personal income taxes would be allowed if medical expenses of the family members included on the tax return exceed 15 percent of modified adjusted gross income. (Adjusted gross income would be modified by reducing it by the personal exemption of $750 for each family member and making other modifications described later.) The amount of the credit would be 85 percent of the medical expenses which exceed the 15 percent of income. Thus, the proposal in effect incorporates an income-related deductible and a constant coinsurance rate.

For example, for a family of four with adjusted gross income of $9,000 ($6,000 after personal exemptions of $750 each) and medical expenses of $2,000, the tax credit would be calculated as follows:

| | |
|---|---|
| Medical expenses | $2, 000 |
| 15 percent modified family income (of $6,000) | −900 |
| Total | 1, 100 |
| Tax credit (85 percent of $1,100) | 935 |

Adjusted gross income would be modified (in addition to deducting personal exemptions) by adding any capital gains and interest on certain government bonds which are excluded from adjusted gross income under present tax law.

The medical expenses included for the tax credit would be out-of-pocket expenses paid or incurred for (1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, (2) medicine and drugs, and (3) amounts paid during the taxable year for insurance which constitutes medical care for the taxpayer, his or her spouse, and dependents. With regard to the last item, taxpayers whose modified adjusted gross income was less than $10,000 could include, for purposes of a tax credit, 100 percent of the amounts paid as health insurance premiums. All other taxpayers could include only one-half of such amounts.

Present tax law provisions regarding the deduction of health insurance premiums and the special provisions relating to the deduction of expenses for drugs and medicine would be replaced by a new medical expense definition. The new definition of medical expense, however, would apparently not include the deduction allowed under present tax law for transportation costs incurred in obtaining medical care.

## D. Administration

The Federal agency responsible for administering the tax credit system would be the Internal Revenue Service. Persons would be required to file an income tax return to claim a credit. For purposes of determining the dollar amount of the deductible applicable to his eligible medical expenses, the individual would have the option of using his "modified adjusted gross income" in the current or the preceding taxable year. The individual could claim a tax credit for medical expenses at the time he files his annual Federal income tax return for the current taxable year, or he could file an amended return for the preceding year. In the case of the individual filing an amendment to the previous year's return, he would indicate that his paid or incurred medical expenses for the current year exceeded the 15 percent deductible applicable to his modified adjusted gross income for the preceding taxable year. The individual would then receive an immediate 85 percent refund of those medical expenses exceeding the 15 percent deductible.

### E. FINANCING

The proposal would be financed from Federal general revenues. The bill would repeal the present medical expenses deduction provisions of the income tax law.

### F. PAYMENTS TO AND STANDARDS FOR PROVIDERS OF SERVICES

No provisions.

### G. RELATIONSHIP TO OTHER GOVERNMENT PROGRAMS

The President would be authorized to study the adequacy of the tax credit proposal in meeting the health needs of the nation and to recommend whether medicare, medicaid, and other Federal medical assistance and health care programs should be terminated, reduced, or changed.

### MAJOR NEW FEATURES

1. The new bill allows taxpayers with less than $10,000 in modified adjusted gross income to include 100 percent of amounts paid for health insurance in calculating total medical expenses for purposes of a tax credit. Taxpayers with more than $10,000 in modified adjusted gross income could include only one-half of such amounts. The old bill had permitted inclusion of only one-half of those amounts paid for health insurance, regardless of the income level of the taxpayer.
2. The new bill provides for an annual determination of the medical insurance income criterion to be made by the Secretary of the Treasury, reflecting increases or decreases in the Consumer Price Index.
3. The new bill specifies that regulations prescribed for the tax credit program may in no way limit an individual's right to choose his own licensed health care provider or place of treatment.

## 7. The National Health Care Act of 1975 (H.R. 5990; S. 1438)

*Date introduced.*—April 15, 1975.

*Chief sponsors.*—Representative Omar Burleson, Senator Thomas McIntyre.

*Earlier versions.*—91st Congress, H.R. 19935 (Dec. 10, 1970); 92d Congress, S. 1490 (Apr. 5, 1971), H.R. 4349 (Feb. 17, 1971); 93d Congress, S. 1100 and H.R. 5200 (Mar. 2, 1973).

### A. GENERAL APPROACH

The bill proposes three voluntary health insurance plans which would include (1) an employee-employer plan, (2) an individual plan, and (3) a State plan for the poor and near poor. After a phasing-in period, all plans would be required to provide as a minimum a broad range of health care services, with benefits generally subject to cost-sharing by the patient. All plans would be administered through private insurance carriers, with overall program supervision by the State and Federal Governments. The qualified employee-employer plan and the qualified individual plan would be financed by premium contributions and contributors would receive tax advantages. The State plan for the poor and the near poor would be financed primarily by Federal and State general revenues with some premium contributions from the near poor. The bill includes various provisions designed to increase the supply of health manpower, to encourage the development of ambulatory care centers, and to strengthen health planning.

## B. People Covered

Private health insurance covering minimum standard health care benefits would be made available to all U.S. citizens through three separate plans as follows: (1) qualified employee health care plans, (2) qualified individual health care plans, and (3) qualified State health care plans. Under the employee plans, persons working for employers who voluntarily establish a qualified plan would be covered. Such a plan would be required to cover full-time and part-time employees (who work at least 20 hours a week for at least 26 weeks diring the year) and their dependents.

Coverage under the plan would continue, as follows: (1) 2 months after layoff or termination of employment; (2) 2 months of coverage for the surviving family in case of the employee's death; (3) 30 months if absent because of illiness or disability.

Under the individual plans, all persons would be eligible to purchase voluntarily a qualified individual health insurance policy for themselves and their families. The individual health care plan would provide income tax incentives to encourage the purchase of individual (nongroup) qualified health insurance. The premiums would be paid by the policyholder. This plan would make qualified insurance available to self-employed persons and others not eligible under the employee or State plans (as described below).

The State health care plan would provide benefits for the poor and near poor by establishing State pools of private health insurers. Any individual or family (1) on welfare, or (2) who has adjusted gross annual income of less than $5,000 as an individual, $7,500 as a family of two, or $10,000 as a family of three or more, and is not eligible to join a qualified employee plan, would be eligible to join the State plan on a subsidized basis. The poor would pay no premium; others would pay a partial premium scaled to income. Laid-off employees who meet the income test for 2 consecutive months would also be eligible. The income limits applicable to eligibility for the State plan would be adjusted to reflect increases or decreases in the Consumer Price Index.

## C. SCOPE OF BENEFITS

Minimum standard benefits would be identical for all three plans (with variable cost-sharing amounts as noted later) and would be phased-in in two stages, as follows:

*Phase I—1977*

1. For both physical and psychiatric care, unlimited hospital inpatient and outpatient services.
2. All professional services for the diagnosis or treatment of injuries, illness, or conditions other than dental and mental, by or at the direction of a physician.
3. The first 20 out-patient mental health visits to a physician or community mental health center.
4. Prescription drugs and contraceptive devices.
5. 180 days of skilled nursing care.
6. 270 days of home health care services.
7. Use of radium or other radioactive materials, oxygen, anesthetics, prostheses other than dental, and rental of medical equipment.
8. Oral surgery on impacted teeth, and for a tooth root.
9. Diagnostic X-rays and laboratory tests performed other than while an inpatient in a hospital or skilled nursing facility.
10. Well child care, including immunizations, for children under age 5.
11. One oral exam per year, including prophylasix, dental X-rays, topical application of fluoride, and insertion of space maintainers by a dentist, or at his direction, a dental hygenist, for children under age 13.
12. One eye refraction per year for children under age 13.
13. Counseling on family planning and fitting of contraceptive devices.
14. One Pap smear every 2 years for women age 19 and over.

*Phase II—1985*

All of the above listed services and items, plus the following:

15. Dental care for fillings and extractions.
16. Other dental services and prostheses, except orthodontia.
17. Services of a physical therapist.
18. Services of a speech therapist.
19. One eye refraction every 3 years for persons age 13 or older.
20. One pair of eyeglasses per prescription, with a limit of one prescription per year for persons under age 19, one prescription every 3 years for those over 19.
21. One hearing exam every 3 years.
22. Hearing aids—one per 3 years under 19, one per lifetime over age 19.
23. One physical exam every 5 years for persons 5 years or older.

The bill would allow private insurance plans for employees and individuals to apply a deductible of not more than $100 to covered benefits prior to January 1978. After that time, the deductible amount could be adjusted to reflect changes in the Consumer Price Index. Once the deductible had been satisfied, the private plans would pay at least 80 percent of expenses for covered services (except for outpatient mental health visits and certain routine dental care, where the plan might pay only 50 percent. There would be a limit of $1,000 on total copayment and deductible charges per family in any 12-month period.

In addition, no copayments would be allowed on items 9 through 14 after phase II had begun. A plan could, at its option, require a lesser deductible or copayment, or waive such cost-sharing entirely with respect to one or more items of covered expense.

Under the State plans for the poor and near-poor, all such cost-sharing amounts (deductibles, coinsurance, and total liability) would be adjusted according to ability to pay. Deductibles would range from $10 for a single individual with adjusted gross income of less than $1,000 and a family of three or more with income less than $2,000, to $90 for individuals with less than $5,000 in adjusted gross income and families of three or more with income less than $10,000. The total amount of cost-sharing (deductible plus coinsurance) would be limited to 10 times the amount of the deductible determined to be applicable to a particular individual or family in any given policy year, e.g., the single individual with less than $1,000 income and a $10 deductible would be responsible only for a total of $100 in cost sharing for covered benefits.

## D. Administration

Private insurance carriers would administer their own policies for qualified group and individual plans. The policies must be approved by the State insurance department as satisfying the requirements for a qualified policy. Carriers would collect premiums, process claims for benefits, etc. The bill contains various financial and other requirements which would pertain to carriers underwriting insurance under the program.

For the qualified State health care plans, each State would establish a health insurance pool, a portion of the risks of which private carriers participating with qualified plans would be required to underwrite. One or more private carriers would be designated to administer the State plan. Premium rates for the State plans would be determined within each State, subject to review by HEW.

State insurance commissioners would also be responsible for establishing and regulating an underwriting and reinsurance facility which would make minimum standard health care benefits available to individuals, families, and groups of less than 50 employees or members for whom such benefits would not otherwise be available. The underwriting risk for those persons previously uninsurable for health reasons would be borne entirely by the health insurance industry.

## E. Financing

Private group and individuals plans would be financed by premium contributions from the policyholders. A portion of the cost of this protection would be met by reductions in Federal income tax collections. The Internal Revenue Code presently restricts an individual's deduction for health insurance expense to an amount (not in excess of $150) equal to 50 percent of the total premium payments. The portion of the expense not so deductible may be deducted only to the extent that it exceeds 3 percent of adjusted gross income. The bill would amend the Internal Revenue Code for taxable years commencing after December 31, 1976, so as to allow 100 percent of health care insurance premiums as a deduction, if such expenses were paid by an individual who is covered by a qualified individual health care plan, a qualified employee health care plan, or a qualified State health care plan.

In addition, beginning in 1977, the amount of tax deductibility allowed an employer for health insurance expenditures on behalf of his employees would be reduced from 100 percent to 50 percent, further reduced to 25 percent in 1978, and completely eliminated after 1978. However, if the employer established and maintained a qualified employee health care plan which contained the minimum standard health benefits established by the Government, then this restriction would not apply, and 100 percent of the employer's health insurance premium expense would be deductible.

Employees could be required to contribute to the premiums, and the percentage of participation of each party could be dependent on collectively bargained agreements. The employee's share in the premium payment would be income-related and limited to 10 percent of his monthly wages in excess of specified monthly income levels (adjusted to the Consumer Price Index).

The State plan would be financed by premium payments of enrolled families, graduated according to income, and by contributions from State and Federal general revenues. Persons on public assistance would not be required to pay any portion of their premiums, which would be paid by the State on their behalf. All other persons covered under the State plan would be required to contribute toward the premium cost of the plan in accordance with a formula reflecting changes in the CPI, as well as differences in income levels. For example, a single individual with income of $4,000 would pay a monthly premium of about $17; the individual with income of $5,000 would pay $25. A family of 3 or more with income of $8,000 would pay a monthly premium of about $33, while the family with $10,000 income would pay $50 a month.

Each State would have the primary obligation to provide the administering carrier that portion of the total premium cost not payable by enrolled individuals and families. However, if the State implements and utilizes controls which are designed to promote the delivery of lower cost, higher quality institutional health care services, if it exempts qualified State health care transactions from State taxation, and if it levies taxes equally on all health insurance carriers in the State, then the State would receive Federal appropriations reimbursing it for a percentage of its total premium cost not contributed by enrollees. This Federal percentage would be graduated according to State wealth, but in no case would it be less than 70 percent or more than 90 percent of total premiums paid by a State under its State health care plan.

If the premiums collected and other funds received under the State plan are not sufficient to pay the claims incurred and other costs of operating the State plan, the private underwriters of the plan would be responsible for losses up to an amount mutually agreed upon from time to time by the State insurance commissioner, the administering carrier, and three members of the American Academy of Actuaries. Losses above this limit would be borne by the State, which would receive a Federal appropriation reimbursing it for that portion of the excess losses equal to the base Federal percentage for that State's premium cost.

## F. Payments to and Standards for Providers of Services

Present methods under private insurance for reimbursement for services rendered would prevail, except that payments would be limited to the 75th percentile of reasonable charges for professional services, and to rates approved by State health care institutions cost commissions and HEW for health care institutions. Increases in the reasonable charge for any given health care service or article would be related to percentage increases in the Consumer Price Index.

In reviewing the proposed charges for health care institutions in the State, the State health care institutions cost commission would require at least the following standards for each institution: (1) an active review committee of qualified physicians and other personnel who would determine whether health care services rendered are of good quality and necessary for treatment: (2) utilization of a standard system of accounting and cost finding established by the commission; (3) utilization of the approved charges for all patients; and (4) a budget of its expenses for each fiscal year, using the approved standard system of accounting and cost finding, and established charges for services reasonably related to the cost of efficient production of such services.

### G. EFFECT ON OTHER GOVERNMENT PROGRAMS

The Health Care Act would supplement medicaid and medicare. Persons age 65 and over could be covered under the State plan if they meet the conditions for enrollment in the plan, and if, in addition, they are enrolled in the voluntary supplementary medical insurance plan (part B) of medicare. If their income is above the specified limits, so that they would be required to pay premiums, the amount of the premium would be reduced by the amount of the part B premium. If their income is below the specified limits, the State would pay the part B premium on their behalf from State general revenues. Most other Government programs would not be affected.

### H. OTHER MAJOR PROVISIONS

The bill includes provisions which would provide grants and loans to: (1) increase and redistribute the supply of health manpower; (2) promote ambulatory care; and (3) strengthen health planning. Also, the bill would establish in the Executive Office of the President a Health Policy Board which would: (1) recommend procedures for coordinating, consolidating, or eliminating health programs of the various Federal agencies and departments; (2) conduct health research; (3) provide guidelines for health care funding allocations; (4) develop recommendations for national policy to improve the organization, financing, delivery, and quality of health care; and (5) help prepare the President's annual health report.

## MAJOR NEW FEATURES

1. Simplification of the *benefit structure*, patient *cost-sharing* arrangements, and priority *phase-in*—the new bill makes a substantial change in the outline of the benefit structure, the amount of patient cost-sharing attached to covered benefits, and the timetable for phasing-in of benefits. Although the actual services covered under the old and new bills are basically similar, the new bill would provide the same benefits at the same time to all persons covered under all three plans—the employee plan, the individual plan, and the State plan. The old bill had provided initially broader benefits to low-income groups covered under the State plans, with a more gradual expansion in the amount and nature of benefits provided through the employee and individual plans.

The new bill alters the cost sharing arrangements by applying flat deductible and coinsurance amounts (with limited maximum liability) to covered benefits; the old bill had utilized a variety of fixed dollar copayments with coinsurance in a few limited instances, and a catastrophic benefit linked to income rather than a percentage of the deductible amount as provided in the new bill. The new bill also specifies a two-tier benefit phase-in, with full benefits in force in 1985. The old bill had enumerated three separate phase-in periods, with allowance for a Presidential deferral of the full range of benefits if facilities and services were not available to meet the anticipated greater demand.

2. The new bill has broadened the definition of the term "physician" to include *optometrists* and doctors of clinical *psychology*.

3. The new bill specifically excludes from coverage under any qualified plan those services and articles for which benefits are payable under any *no-fault insurance* policy.

4. The new bill provides a definition of the term "*community mental health center*."

5. The new bill contains a limitation on malpractice judgments, disallowing damages for the cost of remedial services for which the injured party was or is entitled under the act.

6. The new bill raises the *dependent child age limit* to 25 if the individual is a full-time student.

7. The new bill modifies the formula applicable to the amount of employee contributions under a qualified employee health care plan; rather than utilizing fixed dollar amounts as under the old bill, the new bill's formula is linked to changes in the *Consumer Price Index*, thus rendering it dynamic. The new bill utilizes the same approach with regard to establishing income eligibility levels under the State plans and the amount of cost-sharing required of persons in different income groups. Percentage increases in the CPI would also be utilized to determine the amount of increase in the "reasonable charge" reimbursed for covered physicians' services.

8. The new bill contains an additional qualification pertaining to approval of a State plan eligible for Federal funds—a State would not be allowed to reduce the scope of its State laws concerning *workmen's compensation*, and it would be required to establish and implement regulations governing the operation of an underwriting and reinsurance facility (noted in item 9).

9. The new bill directs State insurance commissioners to assure the establishment and regulation of a facility to underwrite or reinsure maximum standard health care benefits for individuals, families, and groups of less than 50 employees or members to whom such benefits would not otherwise be available. This provision is designed to make insurance available to persons previously considered "uninsurable." The old bill had had specific allowance for coverage of uninsurable individuals under the various State plans for low-income persons. Under the new bill's provision, "uninsurable" individuals or groups would be covered either through a qualified individual plan or employee plan, rather than the State plan, unless, of course, the income test for the State plan was satisfied.

## 8. The Comprehensive Health Care Insurance Act of 1975 (H.R. 6222)

*Date introduced.*—April 22, 1975.

*Chief sponsor.*—Representative Richard Fulton.

*Earlier versions.*—None—bears some similarity to Administration bill (H.R. 12684) and "Medicredit" proposal (H.R. 2222) in 93d Congress.

### A. General Approach

The bill would require employers to provide employees with comprehensive health care insurance coverage purchased from qualified private health insurance carriers. Employers would have to pay at least 65 percent of the premium cost; acceptance of coverage by the employee would be optional. Federal subsidies in the form of cash payments or tax credits would be available to employers who experienced substantial cost increases as a result of complying with the requirement for health insurance coverage.

Federal income tax credits would be utilized to provide health care insurance protection for the non-employed, self-employed, and elderly. The amount of the credit would be scaled according to income tax liability; those persons who have no tax liability would be eligible to receive a certificate or voucher with which to purchase qualified private coverage.

Benefits would be comprehensive in scope and would not be subject to payment of a deductible; however, 20 percent coinsurance would be applied to covered services, with the total amount of coinsurance in any one year limited according to income.

### B. People Covered

All employers, including Federal, State, and local governments, would be required to make health insurance coverage available to all their full-time employees (who work at least 20 hours a week on a continuing basis) and their employees' families. Acceptance of coverage would be optional on the part of the employee, although the employee's decision would have to be rendered within 30 days of beginning employment or during an open enrollment period.

Nonemployed or self-employed U.S. residents and their families who are not eligible for an employer-sponsored plan would be eligible for the tax credit provisions of the bill. Individuals eligible for medicare would also be entitled to the tax credit provisions or for health insurance certificates for coverage supplemental to medicare.

Temporarily unemployed persons receiving Federal or State unemployment compensation benefits would be eligible for a federally financed program paying the full premium for continuation of the qualified health care insurance previously furnished through the employer and in effect at the time employment was terminated. Coverage under the Federal program for the temporarily unemployed would continue until the employee became reëmployed or until 30 days following the expiration of unemployment compensation benefits.

## C. Scope of Benefits

A qualified health insurance plan for purposes of either the employer-sponsored coverage or Federal tax credits for the nonemployed, self-employed, and elderly would have to provide as a minimum the following benefits during any policy year:

1. 365 days of inpatient hospital care.
2. 100 days of skilled nursing facility care.
3. All home health services to an individual under a physician's care.
4. All emergency and outpatient services normally provided by a hospital, including X-rays, lab tests, etc.
5. All diagnostic, therapeutic, and preventive medical care by a doctor of medicine or osteopathy, where ever provided including but not limited to physical exams, immunizations and inoculations, well-baby care, services for pregnancy, diagnostic X-rays and lab services, psychiatric care, etc.
6. Routine dental care (including diagnosis, therapy, and treatment) initially for children ages 2 through 6, with the covered age group gradually to be expanded to include children through age 17.
7. Emergency dental services and oral surgery for all ages.
8. Medically necessary ambulance service.

No deductible would be applied to covered benefits. However, an individual or family would be liable for 20 percent coinsurance on all covered items and services, with the total amount of coinsurance in any year limited according to income. The poor would pay no coinsurance; for all others, the ceiling on coinsurance would rise gradually. For example, a family of four would pay no coinsurance unless its income exceeded $4,200, at which point its ceiling would be 10 percent of the excess over $4,200. At the $5,000 level, for example, the maximum coinsurance for a year would be $80 ($5,000 less $4,200 times 10 percent). Regardless of income, the coinsurance ceiling would not be more than $1,500 for an individual nor more than $2,000 for any family. The coinsurance ceiling would trigger catastrophic expense protection. All benefits under the insurance policy would thereafter continue for the remainder of the policy with no further obligation for coinsurance.

## D. Administration

Private insurers offering qualified health insurance plans would directly administer claims for benefits and payments to providers. The Federal Government would continue to administer the medicare program as it now does, through carriers and intermediaries. State governments would continue to regulate insurance within the State; an appropriate State agency (generally the State insurance department) would be responsible for approving private carriers for participation in the program.

A 15-member Health Insurance Advisory Board would be created at the Federal level to prescribe regulations for the program as necessary, establish Federal standards for use by State insurance departments in regulating insurance companies, consult with carriers, providers and consumers in planning and developing programs for quality medical care, etc.

In order to be qualified for participation in the program, private insurance carriers would have to be authorized by the appropriate State agency, agree to participate in an assigned risk pool, provide qualified health care insurance as defined in the bill, and provide specified open enrollment periods. Carriers would be required to offer assistance to individuals in preparing and filing applications for certificates of entitlement (to a health insurance premium subsidy) and to provide prompt health insurance coverage to such individuals pending issuance of the certificate. Carriers would also be required to identify medical expenditures in accordance with a classification system and to assure confidentiality of medical records.

### E. Financing

The mandated employer plans would be financed through premium contributions from the employer and employee, with the employer required to pay at least 65 percent of the premium. The amount of the premium would be negotiated between the employer and the carrier. Premiums for employee groups of up to 100 persons, and for the self-employed, could not exceed 125 percent of the average premiums in the State for employee groups of more than 100 persons.

Employers whose payroll costs increase by more than 3 percent as a result of purchasing mandated coverage for employees would be eligible for Federal assistance in the form of cash payments or tax credits for the first 5 years of the program. The Federal subsidy would range from 80 percent in the first year to 40 percent in the fifth year of the amount by which the total payroll cost increase exceeds 3 percent of the total payroll costs of the employer. A continuing study by HEW would determine the need for any future subsidies.

Health insurance for the nonemployed and self-employed would be financed through premium payments to private insurers, for which the insured individual would be eligible for either a Federal tax credit or a federally issued health insurance certificate acceptable by the private insurer in payment of the health insurance premium. The amount of Federal premium assistance in each case would be determined on the basis of income tax liability. Persons with no tax liability would receive a Federal contribution equal to 100 percent of the health care insurance premium. For others, Federal assistance would range, between 99 percent and 10 percent of the premium. For example, a family of four with a $6,000 income resulting in a $159 tax liability would be entitled to have 84 percent of the premium paid by the Federal Government.

Nontaxable income would be included in the income computation in determining the amount of Federal premium assistance on the following basis: for each $100 of such nontaxable income (exclusive of the first $4,000 of pension or social security income), the amount of Federal premium assistance otherwise applicable (either as a tax credit or certificate) would be reduced by 1 percentage point.

An employed person entitled to coverage under an employer plan could not elect coverage under the program for the nonemployed. As an equalizer, however, he could claim a tax credit (or apply for a certificate) in the amount by which his share of the premium as an employee exceeded what he would pay as a nonemployed person under the subsidy program. The bill also specifically allows self-employed persons to claim as a business expense 65 percent of the premium cost of qualified health insurance; normally, tax law does not allow self-employed persons to qualify as employees for purposes of business expenses related to health insurance.

Nonemployed persons aged 65 and over who are eligible for medicare would also be eligible for a Federal subsidy under this program on the same basis and in the same manner as described above for self-employed and nonemployed persons under age 65. However, the subsidy in this case would be applicable only to a premium for "qualified supplemental coverage" designed to equalize the available benefits for the elderly as for all others. Such supplemental insurance would be the same in content as the full insurance policy for persons under 65, but would contain a clause excluding payment for all benefits obtainable by medicare eligibles under parts A and B of medicare. The supplemental insurance would not be allowed to cover medicare deductibles and coinsurance and would be required to make its supplemental benefits available without any deductible or coinsurance payments on the part of the insured individual.

Premium payments for the temporarily unemployed would be paid by the Federal Government from general revenues to cover periods of unemployment, until the individual became newly employed or until expiration of his unemployment compensation benefits. Once unemployment compensation benefits were exhausted, the individual would become eligible for Federal assistance to the nonemployed, with full subsidy of the premium for the remainder of the calendar year.

### F. PAYMENTS TO AND STANDARDS FOR PROVIDERS OF SERVICES

Physicians' services would be reimbursed on the basis of "usual and customary or reasonable charges" for covered services; payment for hospital services would be determined by an appropriate State agency, after consultation with providers, on a reasonable cost basis under "acceptable methods of reimbursement including appropriate prospective rate determination systems" (e.g., budget review, negotiated rates, target rates, formula negotiations, etc.). Other costs would be paid on either a reasonable cost or reasonable charge basis, as appropriate.

The Health Insurance Advisory Board at the Federal level would consult with carriers, providers, and consumers to plan, review, and develop programs to maintain the quality of medical care and the effective utilization of available financial resources, health manpower, and facilities through utilization review, peer review, and other means providing for the participation of carriers and the providers of services.

### G. EFFECT ON OTHER GOVERNMENT PROGRAMS

Medicare would continue to cover the aged and disabled as at present; the program would allow medicare eligibles to obtain private coverage supplemental to medicare and receive tax credits or certificates of entitlement toward the costs of such private coverage. Although the bill itself does not amend the Social Security Act to eliminate the title XIX (medicaid) program, the intent of the program is to eliminate the need for medicaid by covering medicaid eligibles under private health insurance plans, either through a mandated employer plan or the tax credit/certificate of entitlement provisions for the nonemployed.

### H. OTHER MAJOR PROVISIONS

The bill provides that, in an action for damages against a medical provider, no liability would be recognized with respect to the costs of health care which are payable under this program or any other health care program under the Social Security Act.

## 9. The Comprehensive National Health Care Act of 1975 (H.R. 6283)

*Date introduced.*—April 22, 1975.

*Chief sponsor.*—Representative Andrew Young of Georgia.

*Earlier versions.*—None, although bears some similarity to H.R. 13870 (Mr. Mills) and H.R. 22 (Mrs. Griffiths) from the 93d Congress.

### A. GENERAL APPROACH

The bill would create a system of national care benefits provided through an independent contributory social insurance program. All U.S. residents would be covered for a comprehensive range of health care benefits, without deductibles, coinsurance, or other forms of patient cost-sharing. The program would be financed through payroll taxes on employers and employees, taxes on self-employed individuals and on unearned income. The program would be administered through a newly independent Social Security Administration, with a role for private insurance carriers in the first 10 years of the program's existence.

### B. PEOPLE COVERED

All U.S. residents (without any restrictions or required history of contributions to the program) would be eligible for health care benefits under the program. Residents of foreign nations with which the U.S. had in effect reciprocal agreements for payment of health care benefits would also be eligible while they are physically located in the United States.

### C. SCOPE OF BENEFITS

Benefits covered under the national health care program would be as follows:

1. Inpatient hospital services, with no day or dollar limitation;
2. Physicians' services, in home, office, or elsewhere, with no dollar limits (includes well-child care, prenatal care, family planning, etc.);
3. Medical and other services (as now defined under medicare, for example, prosthetic devices, dialysis equipment and supplies, X-rays, laboratory, ambulance, etc.);
4. Home health services—180 visits per year;
5. Posthospital extended care services—180 days per year;
6. Outpatient drugs and biologicals from an approved formulary;
7. Routine dental services;
8. Developmental vision care services, routine eye and vision exams, eyeglasses;

9. Hearing aids and exams;

10. Routine physical exams and other prophylactic care (as defined in regulation);

11. Mental health services—inpatient 45 full days of active treatment in a psychiatric hospital, or 90 partial days; outpatient services in a comprehensive community care center equivalent to the costs of 50 visits to a private practitioner and outpatient services of a private practitioner equal to two-thirds of the costs of 50 visits.

No deductibles, coinsurance, copayments, or durational limits (other than those indicated above) would be applicable to covered benefits. Services listed above would be covered for all individuals under the program, regardless of age or income category.

### D. ADMINISTRATION

The present Social Security Administration would become a new independent agency headed by a Social Security Board composed of three members (no more than two members from the same political party). The independent Social Security Administration (SSA) would continue to administer the present cash social security program, the supplemental security income program, and the national health care benefits program established under the bill.

For institutional services, SSA would use intermediaries much as it now does under the medicare program. For physicians' services and other non-institutional services, private insurance carriers approved by SSA could be selected by those employers having 1,000 or more employees to administer the program on behalf of the employees (and their dependents) of that employer. Such employers, as well as institutional providers, would have the option of dealing directly with SSA. For all people not covered through large employer groups, carrier contracts would be awarded by SSA on a competitive basis in each geographical area of the country for 2-year terms. To be eligible for approval under the program, private carriers must have underwritten at least 1 percent of the total 1974 health insurance business and provide assurances of no discrimination in employment practices, writing or underwriting health insurance policies, or in claims operations for 2 years prior to the effective date of any SSA contract. All such contracts between SSA and private carriers would automatically terminate no later than 10 years after the effective date of the program, thereby discontinuing any further role for private carriers in the administration of the health care benefits program.

Every insured individual would be issued a health benefits card, similar to a credit card, indicating his status as an insured individual for the purposes of covered benefits. The SSA or a consortium of participating carriers at their request, would be responsible for administering the operation of the health benefits card system. Under this system, participating providers would not collect their charges from the patient, but would be paid in full by the program.

The bill would also create Area Health Care Services Boards in each geographic area designated as a PSRO area. These boards would consist of 15 members (including 5 representatives of health providers and 10 representatives of health consumers) who would be responsible for consulting with SSA on prospective payment methods for providers of service, and awarding of incentive payments, concurring with various actions of SSA regarding providers and contracts with carriers, determining compliance by providers of services with conditions of participation in the program, and for establishing the fee schedules applicable to services of physicians and other health professionals.

A National Health Care Benefits Advisory Council with 19 members (at least nine of whom are members of the general public with no financial interest in providing health services) would be created to advise SSA on general policy matters.

### E. Financing

The program would be financed from the following sources:

1. A 5-percent tax on unearned income and self-employment earnings;
2. A 2-percent payroll tax on employees' wages;
3. A 6-percent tax on employers' payroll.

The contribution base for purposes of the health care benefits program would be unlimited.

The bill stipulates that Federal income tax credits would be available to contributors to the program in an amount equal to one-half of the amount paid in the taxable year for purposes of the health care benefits program. For employees and self-employed individuals, the total amount of the credit would be limited to $250 ($500 for joint returns). For employers, the amount of the credit would be limited to $750, times the number of individuals for whom the tax had been paid by the respective employer.

### F. Payments to and Standards for Providers of Services

The standards for the various payments of services under the program would resemble those now used in the Medicare program. State health agencies and/or area health care services boards would be used to determine compliance with the conditions of participation for hospitals, skilled nursing facilities, intermediate organizations, neighborhood health centers and community mental health centers. Payments to institutional providers of services would be on the basis of a variety of prospective payment systems with incentive payments (called quality management payments) to better performing providers; two-thirds of the incentive payment to a provider would have to be passed on to the provider's staff and employees.

Payments for the services of physicians and certain other professional practitioners would be on the basis of fee schedules established by the area health care services boards. The schedules would have to be accepted by the Social Security Administration if actuarial calculations showed that the resulting costs would not exceed those actually experienced in a base year adjusted for changes in prices and earnings under an index reflecting such changes.

Physicians who choose to participate in the program would receive the full fee schedule amount directly from the program for all services to all their patients. In the case of physicians who do not participate, payment at the fee schedule amount would be paid by the program directly to the patients; non-participating physicians would have to look to the patient for payment of their full charges, which could exceed the fee schedule amount.

For all other covered items and services, payment would be made—as under the medicare program now—on the basis of the lowest cost of the items or services which are widely and consistently available in a locality.

Conditions of payment for covered services would resemble those now applied to the medicare program with the following additions:

Payments would not be made to any institutional provider for services whose character or quantity had not received the positive endorsement of the State and local health planning agencies for the year being budgeted; payment would not be made for certain physicians' services unless performed by recognized specialists; surgery could be performed only after the patient had been referred to a surgeon by a primary physician; certain surgical and other major procedures would be performed only after consultation with an additional specialist; payments for certain specialized procedures could be reduced where there was found to be an overabundance of specialists in the same area; and all covered services would have to be reviewed by the professional standards review organization in that area, effective 2 years after the program begins.

### G. Effect on Other Government Programs

Medicare would be replaced by the new program. The Veterans' Administration would continue to operate a separate health care system for those eligible for VA benefits.

### H. Other Major Provisions

The bill authorizes transfer of funds from the trust fund established for the health care program to the Secretary of Health, Education, and Welfare for purposes of title XVI of the Public Health Service Act in the following amounts: (1) 2 percent of the total amount in the fund, for fiscal year ending September 30, 1978, (2) 1½ percent of the total for fiscal year ending September 30, 1979, (3) 1¼ percent of the total for fiscal year ending September 30, 1980, and (4) 1 percent of the total for fiscal year ending September 30, 1981, and thereafter.

## 10. The Catastrophic Health Insurance and Medical Assistance Reform Act (H.R. 10028; S. 2470)

*Date introduced.*—October 3, 1975.
*Chief sponsors.*—Representative Joe Waggonner, Senators Russell Long and Abraham Ribicoff.
*Earlier versions.*—93d Congress, S. 2513 and H.R. 14079 (Oct. 2, 1973).

### A. General Approach

The bill would provide catastrophic health insurance protection for all legal U.S. residents through one of the following plans: (1) a federally administered public plan for the unemployed, welfare recipients, the aged, and persons who do not opt for private insurance coverage, and (2) a private catastrophic insurance plan allowed an an option for employers and the self-employed, who would be required under the terms of the bill to provide and pay the full cost of such catastrophic protection for their employees. Benefits would be similar to those currently covered under medicare, but would be subject to payment by the beneficiary of the first 60 days of hospital care and the first $2,000 in medical expenses. The program would be financed through a 1-percent tax on the payroll of employers, with 50 percent of the amount paid as payroll tax allowed as a tax credit. Employers opting for a private plan would have the amount of their premiums deducted from their 1 percent payroll tax liability.

They would also be eligible for a 50 percent tax credit on *both* the total amount of premiums paid for catastrophic coverage and any remaining Federal payroll tax liability after the premiums have been deducted.

In addition, the bill would replace medicaid with a uniform, national program of medical benefits for low-income persons, administered by the Department of Health, Education, and Welfare. The bill further provides for a voluntary Federal certification program for basic private health insurance to encourage private insurers to make such basic coverage (supplemental to the catastrophic program) available in all areas of the country. If private insurers failed to make certified basic private health insurance available in any State, the Secretary of HEW would be empowered, 3 years after the enactment of the program, to offer a standard health insurance policy to individuals and families living in that State.

## B. People Covered

Under the catastrophic health insurance plan, every individual who is a resident citizen or a lawfully admitted resident alien would be entitled to catastrophic health insurance benefits under either the public plan or the private plan for employers and the self-employed. All employers, including Federal, State, and local governments, would be required to provide for all their full-time employees (who work more than 25 hours per week) and their employees' spouses and dependent family members the health insurance protection as specified in the bill. At their option, employers could also include part-time and temporary employees. An employer would be obligated to continue coverage for 90 days after an employee left his employment unless the employee obtained coverage under another employer plan. Federal, State, and local governments would be considered employers for purposes of the catastrophic program.

The unemployed, welfare recipients, the aged, and all others not covered under an employer or self-employed private catastrophic plan would be covered under the public plan.

The *medical assistance plan* for low-income persons would be available to all persons eligible for medicaid benefits during the period from January to July 1977 and all individuals and families having an annual income at or below the following levels: $2,400 for an individual; $3,600 for a two-person family; $4,200 for a three-person family; $4,800 for a four-person family; and $400 additional for each additional family member.

Families with incomes above these levels would become eligible if they spent enough on medical care to reduce their income to the eligibility levels. Thus, a family of four with an income of $5,000 would become eligible if it spent $200 for medical care.

## C. Scope of Benefits

The *catastrophic plan* would cover the same kinds of services as currently provided under parts A and B of medicare, except that there would be no upper limitation on hospital days or home health visits. Present medicare coverage under part A includes 90 days of hospital care, plus an additional lifetime reserve of 60 hospital days; 100 days of posthospital extended care; and 100 home health visits during the year following discharge from a hospital or extended care facility. Part B coverage includes physicians' services, 100 home health visits annually, laboratory and X-ray services, outpatient physical therapy services, and other medical and health services such as medical supplies, appliances and equipment, and ambulance services.

Benefits excluded from medicare would also be excluded under this program. Medicare's limitation on skilled nursing care would also be retained. The catastrophic plan would apply different limits on inpatient and outpatient mental health services than those currently applicable under medicare (i.e., 190-day lifetime maximum in psychiatric hospitals, $250 maximum payable for outpatient mental health care); the catastrophic plan would cover (1) unlimited inpatient services, consisting of a course of active care and treatment provided in an accredited medical institution, (2) unlimited mental health care services provided on a partial hospitalization basis by an accredited medical institution or qualified community mental health center, (3) unlimited outpatient services provided by a qualified community mental health center, and (4) 5 visits to a privately practicing psychiatrist during any 12-month period, unless additional visits have been approved in advance by an appropriate professional review mechanism on the grounds that the patient would require institutional care in the absence of such additional outpatient visits.

Unlike medicare, which provides *basic* insurance coverage, the catastrophic health insurance program would provide institutional benefits only after an individual had first been hospitalized for a total of 60 days in one year (this feature of the program is called the "hospital deductible"), and medical benefits only after an individual or a family had incurred medical expenses of $2,000 for physicians' services, home health visits, physical therapy services, laboratory and X-ray, and other covered medical and health services (this "medical deductible" would be dynamic in character, ajdusted annually to reflect changes in the Consumer Price Index and other economic factors). The plan would have a deductible carryover feature under which days spent in a hospital in the last 3 months of one calendar year could be counted toward satisfaction of the hospital deductible in the following calendar year; similarly, covered medical expenses incurred in the last 3 months of one calendar year could be counted toward meeting the $2,000 medical deductible for the next year. Once the hospital and medical deductibles had been met, the individual would not be charged for services covered under the program. However, following the first period of any 90 consecutive days during which the individual incurred *less* than $500 in medical expenses, catastrophic benefits would temporarily terminate until such time as the individual once again satisfied the medical deductible by incurring $2,000 in additional medical expenses. Similarly, following the first consecutive 90-day period during which an individual was neither an inpatient in a hospital nor an inpatient in a skilled nursing facility, the individual would once again be liable for the 60-day hospital deductible applicable to catastrophic benefits.

The *medical assistance plan* for the low-income would cover the following benefits, generally without any limit on the amount of services or any cost-sharing required, except as indicated:

Inpatient hospital services—60 days in benefit period.

All medically-necessary skilled nursing facility care, intermediate facility care, and home health services.

Physicians' services—$3 copayment for each of first 10 outpatient visits per family, except no charge for visits for well-baby care, family planning, and periodic exams for children under age 18.

Laboratory and X-ray services.

Prenatal and well-baby care.

Family planning, counseling, and supplies.

Periodic screening, diagnosis, and treatment for children under age 18.

Outpatient physical therapy.

Immunizations and Pap smears.

Medical supplies and appliances.

Ambulance services.

Mental health care services as follows: (1) on an inpatient basis—if provided in an accredited institution, services are included in the hospital inpatient benefit if the service constitutes active care and treatment; (2) on a partial hospitalization basis—if provided by an accredited institution or accredited institution or qualified community mental health center; (3) on an outpatient basis—without limit if provided by community mental health center, limited to 5 visits if provided otherwise (e.g., by a psychiatrist) with additional visits subject to approval by a professional review organization. Benefit includes approved drugs when necessary to avoid hospitalization.

The medical assistance plan would also pay the medicare part B premium for eligible individuals and would reimburse an individual for one-half of the amount of the actuarial value of catastrophic health insurance coverage paid by such individual under a self-employed plan or deducted as taxes from his self-employment income.

A special copayment requirement would also apply to individuals who are not a member of a family, after the 60th continuous day spent in a long-term facility. The amount of this copayment would be equal to the amount of the patient's monthly income, less $50. (A similar requirement would apply in a situation where all members of a family have a stay exceeding 60 days.)

### D. ADMINISTRATION

The public *catastrophic insurance plan* would be administered by the Social Security Administration in a manner parallel to the administration of medicare. The private catastrophic plan would be administered by a qualified private insurance carrier of the employer's choice. The Secretary of HEW would be responsible for approving the employer plans and the self-employed plans administered through private carriers. To be approved as a carrier for private catastrophic insurance, an insurance carrier would have to comply with various Federal requirements, including a requirement that the carrier establish claims determination procedures which comply with section 503 of the Employee Retirement Income Security Act of 1974 and are consistent with those procedures employed by the carrier in its noncatastrophic health insurance business; to assist carriers in meeting this requirement, the Secretary would allow carriers reasonable access to claims data developed under medicare's hospital insurance program. Carriers would also be exempted from certain antitrust laws as they might otherwise pertain to a group of carriers entering into a pool, reinsurance, or other residual market arrangement.

The *medical assistance plan* for the low-income would be administered by the Secretary of HEW. Individuals eligible for benefits under the program would be issued a health benefits card indicating that their application for benefits had been filed and approved for a given benefit period. The Secretary would utilize private carriers as fiscal intermediaries responsible for administration of claims and payments to providers of services. The bill also provides that the Secretary could require the consolidation of the activities of these carriers in areas with small populations if necessary to improve quality and efficiency. Three years after the enactment of the program, no private carrier or other organization could be utilized under the medical assistance plan or medicare unless it was approved and certified under the voluntary certification program established under the bill.

## E. Financing

The *catastrophic insurance plan* would be financed through a 1-percent tax on the payroll of employers and the income of the self-employed now subject to the social security tax. No employee contribution would be allowed. Amounts collected as taxes would be deposited in a Federal catastrophic health insurance trust fund. An employer or self-employed individual who opted for a private, rather than public, catastrophic health insurance plan would have the amount of the premium for private coverage deducted from his 1-percent payroll tax liability; he would, however, remain liable for payment to the Federal Government of any difference between the amount paid as premium for a private plan and the 1 percent Federal tax liability. Publicly insured employers and self-employed individuals would be eligible for a catastrophic health insurance tax credit equal to 50 percent of the amount paid as payroll tax liability. Similarly, privately insured employers and self-employed persons would also be eligible for a 50-percent tax credit on the amount paid for private catastrophic insurance premiums, as well as a 50-percent tax credit on any additional amount paid to meet the 1-percent Federal payroll tax liability.

Employers and self-employed persons opting for private coverage would pay premiums directly to the carriers. The bill requires that the employer plans administered through private carriers must make available to the employer certain arrangements for the pooling of risks among various employee groups of different employers, so that premiums can be determined on a class, rather than an individual, basis.

Each year, a five-member Federal Actuarial Committee would prepare a table of values of catastrophic health insurance coverage for the following year, indicating the actuarial value of 1 year's catastrophic health insurance coverage for one individual. This table could be used by the employer as a guideline by which to evaluate the actuarial value of catastrophic health insurance coverage (and the premium charged therefor) offered through private carriers. The Committee would also review the marketing and rating practices of private carriers providing employer and self-employed plans for catastrophic insurance.

The *medical assistance plan* would be financed from general revenues, just as the Federal share of the current medicaid program is now financed, and also with State funds. A medical assistance trust fund would be established to make payments for benefits under the program. States would contribute a fixed amount which would be equivalent to their total expenditures from State funds under medicaid for the types of benefits covered under this plan during the year prior to the effective date of this program. Additionally, a State would also pay 50 percent of the estimated amount that the State and local governments had expended in the same base year for provision of these types of services to people not covered under medicaid who would, however, be covered under the new medical assistance plan. State contributions in future years would be limited to the initial contribution amount.

To encourage States to offer optional services not covered under the medical assistance plan, the State contribution would be reduced by an amount equal to one-half the amount expended by the State from non-Federal funds in providing types of services not covered under this program, but which would have been matched under the medicaid program (such as drugs, dental services, etc.), provided, however, that the State had actually included such types of services under its medicaid plan prior to the effective date of the new program.

### F. Payments to and Standards for Providers of Services

Providers of services under the catastrophic insurance plan and the medical assistance plan would be reimbursed on the same basis as under medicare. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers. Payments to skilled nursing facilities and intermediate care facilities would be reimbursed on a "cost-related" basis.

Payments made under the medical assistance plan, along with any required copayment from the patient, would have to be accepted by providers and practitioners as payment in full for the services rendered, and no persons accepting such payment could charge additional amounts for these services.

Both programs would apply the same standards for providers of services as under medicare. Both plans would also incorporate the quality, health and safety standards, and utilization controls which exist in the medicare program, including review of services by institutional utilization review committees and professional standards review organizations (PSRO's).

### G. Effect on Other Government Programs

The catastrophic insurance plan would supplement benefits provided under medicare for persons covered by that program. The medical assistance plan would replace the existing medicaid program. The catastrophic insurance plan would always be the primary payor in cases where an individual was also entitled to have payment made under either medicare or the medical assistance plan. Nor could payments under the catastrophic plan be denied or reduced because benefits for services covered under that plan were also payable, or had been paid, under any other public or private insurance or health benefits plan.

### H. Other Major Provisions

*1. Voluntary certification program for private basic health insurance*—The bill establishes a program whereby private health insurers could, at their option, submit one or more basic health insurance policies to HEW for certification.

Certification would be based upon certain minimum criteria with respect to adequacy of coverage, conditions of eligibility, actual availability of the policy, and reasonableness of premiums to expenses. State agencies could also be used for certification of basic health insurance policies in States having an approved basic health insurance facilition program. In addition to offering certified basic policies, a private carrier, in order to be "approved," would have to employ effective procedures designed to assure appropriate utilization and cost controls with regard to health services insured under its policies.

Three years after the start of the program, no insurer could serve as a carrier or intermediary for either medicare or the new medical assistance plan unless it offered one or more certified policies to the general public in each geographic area or service area in which it did business. The bill would facilitate establishment of insurance pool arrangements in order to make such certified policies available to the general public with a proportionate sharing of risks and rewards among participating insurers.

2. *Government-sponsored standard health insurance policies on a cost basis.*—Three years after the start of the program, the Secretary of HEW would be required to offer a standard health insurance policy providing basic health benefits to individuals and families living in any State which had neither a basic health insurance facilitation program nor approved basic health insurance policies actually available through private carriers. Premiums charged for such policies would be designed to cover costs, including administrative costs and reserves.

3. *Amendments to medicare.*—Makes several amendments to existing medicare program, designed to (*a*) allow coverage of immunizations on a scheduled allowance basis, (*b*) increase the dollar amount payable for mental health services under part B, (*c*) adjust the amount of premiums for hospital insurance coverage payable for uninsured individuals not otherwise eligible for Medicare, (*d*) clarify provisions relating to payment for extended care services on a cost-related basis, and (*e*) extend coverage under the renal disease program to all individuals with kidney disease, regardless of insured status for purposes of social security benefits.

4. *Philanthropic support for health care.*—Includes provisions designed to encourage philanthropic support for health care, especially in support of experimental and innovative efforts to improve the delivery system.

## MAJOR NEW FEATURES

### TITLE I—CATASTROPHIC HEALTH INSURANCE PROGRAM

*1. Option to purchase private coverage.*—The new bill allows an option to employers and the self-employed to purchase private catastrophic health insurance coverage (meeting Government standards) in lieu of the publicly administered plan; persons taking advantage of the private option would still be liable for the full amount of the 1 percent payroll tax used to finance the plan, but amounts paid as premiums for private catastrophic coverage would be deducted from the actual payroll tax liability.

*2. Financing provisions.*—The old bill had provided for partial employee financing of the program; the new bill provides for total employer (and self-employed) financing of a 1 percent payroll tax with 50 percent of that amount allowed as a tax credit to the employer or self-employed individual.

*3. Benefits.*—The new bill eliminates the old bill's provision for 20 percent patient coinsurance on covered medical benefits after satisfaction of the $2,000 medical deductible; the new bill applies no cost-sharing to either covered hospital or medical benefits once the applicable deductible has been satisfied. Mental health benefits have been broadened over last year's bill; the old bill had applied medicare's limit on inpatient and outpatient mental health benefits, i.e., 190-day lifetime limit for care in psychiatric hospitals, $250 maximum payment for outpatient care.

*4. Eligibility.*—The old bill had linked eligibility for the program to social security status; the new bill extends entitlement to virtually every U.S. resident, without requirements for a history of contributions, etc.

### TITLE II—MEDICAL ASSISTANCE PLAN

*1. Eligibility.*—Income determinations for purposes of eligibility would be based on actual income of individual or family for the *2-month* period immediately preceding the date of filing of an application and the prospective income for the 2-month period immediately following such filing date; under the previous bill, income determinations would have been based on actual income of the *past year*, unless the amount of prospective income for the coming year would be much greater or lesser than the past year's income.

*2. Benefits.*—(*a*) Eliminates copayment on periodic exams for persons under age 18; (*b*) change in relationship to new catastrophic program would now reimburse one-half of the actual value of catastrophic health insurance coverage for individual eligible under title XIX and covered under a catastrophic plan for the self-employed.

*3. Payment for health services.*—Applies "reasonable cost-related" reimbursement provisions, in accordance with regulations of the Secretary, to skilled nursing facilities and intermediate care facilities.

*4. Administration.*—Under the old bill, responsibility for administration of the new title XIX program had been delegated to the Social Security Administration; the new bill vests responsibility directly in the Secretary of HEW.

*5. Optometrists' services.*—The new bill contains a provision which would include optometrists' services as part of covered "physicians' services" in States which had been providing payment for such services under their title XIX programs during all or part of the 2-year period preceding the effective date of the new program.

*6. Income definition.*—The new bill omits from the definition of income for purposes of determining eligibility under the program the following items: "prizes and awards," "proceeds of life insurance policies exceeding the lesser of expenses for last illness and burial or $1,500." The new bill also excludes from income cash gifts of less than $240; the old bill had limited the gift exclusion to gifts of less than $100.

*7. Definition of health care expenses.*—The new bill under "health care expenses" for purposes of the spend-down provision includes one-half of the amount of insurance premiums paid by or on behalf of an individual for catastrophic health insurance coverage under a self-employed plan; "*medical and other health services*" definition has been broadened to include outpatient rehabilitation services.

*8. Definition of intermediate care services.*—Has been broadened to include services in a public institution for the mentally retarded or persons with related conditions.

*9. Definition of mental health care services.*—Amended to include services provided on a partial hospitalization basis by an accredited medical institution or qualified community mental health center.

*10. Definition of outpatient rehabilitation services.*—The old bill had not included such services under its definition of medical and other health services, as noted in item 8 above; the new bill does cover such services and provides a lengthy definition of what would be included for purposes of title XIX.

### TITLE III—PRIVATE BASIC HEALTH INSURANCE CERTIFICATION PROGRAM

*1. Authority to offer basic Government health insurance plan.*—The new bill contains an entirely new provision which directs the Secretary of HEW to make available individual and family health insurance policies on a cost basis in any State which does not have a basic health insurance facilitation program (as described below) and in which there is not actually and generally available one or more basic health insurance policies approved through the Government certification program. Such Government policies would not be offered until 3 years after the enactment of the program.

*2. Basic health insurance facilitation program.*—The new bill contains an entirely new provision which would encourage States to facilitate the offering of certified basic health insurance policies through enactment, amendment, or enforcement of various insurance laws and regulations.

*3. State certification of insurance plans.*—State agencies in those States having a basic health insurance facilitation program could be utilized by the Secretary for the purpose of certifying basic health insurance policies.

*4. Approval of carriers.*—The new bill stipulates an additional condition pertaining to carrier approval—carriers must employ effective procedures and practices designed to assure appropriate cost and utilization controls with regard to covered health services.

*5. Antitrust exemption.*—The new bill has broadened this exemption, as it applies to private carriers offering certified policies, to include (in addition to an "insurance pool") "reinsurance or other residual market arrangements."

## 11. The Maternal and Child Health Care Act (H.R. 12937)

*Date introduced.*—March 31, 1976.
*Chief sponsor.*—Representative James Scheuer.
*Earlier version.*—None.

### A. General Approach

The bill would establish a national system of maternal and child health care. A three-member Maternal and Child Health Board in the Department of Health, Education, and Welfare would administer the provisions of the bill relating to nature and scope of benefits and the administration and method of payment of benefits, and would be responsible for studying the operation of the program and making recommendations for its improvement.

The bill establishes, in addition, an 11-member National Maternal and Child Health Council to advise the Board on matters of general policy and to make overall studies of the operation of the program.

The bill includes such cost control measures as prospective reimbursement for institutions and fee schedules for practitioners, with incentives for use of prepaid practices and physician extenders.

The program would be financed by a payroll tax and by general revenues.

### B. People Covered

All children from birth to age 18 and all pregnant women who are residents of the United States are eligible for benefits.

### C. Scope of Benefits

The program would provide for children a wide range of health care benefits, and for pregnant women, full prenatal, delivery, and postdelivery care.

*Institutional services*

*Children—*

100 days of hospital services annually.

120 days of skilled nursing home services annually.

Rehabilitation services provided in an organized setting limited to 60 visits annually.

Mental health and social services in an organized setting limited to 60 visits annually. Mental health services are covered only when delivered in such institutional settings as community mental health or child guidance clinics.

*Pregnant women—*

All hospitalization required during pregnancy and during delivery.

All hospitalization required for the diagnosis and treatment of conditions related to pregnancy during the 12 weeks following the termination of pregnancy.

*Practitioner services*

*Children—*

Services provided a physician or physician's extender under the supervision of a physician.

Preventive health services including screening, medical history, and physical examination and such screening and preventive health measures as are appropriate to the age of the child. The frequency and the details of these preventive health visits are to be determined by the Maternal and Child Health Board in consultation with the Maternal and Child Health Advisory Council.

All professional services for sick children subject to a 10 percent coinsurance fee paid by the patient to the provider.

Dental services covered include preventive services, diagnostic services, and therapeutic services, for children over the age of 4 years.

All major surgery if performed by Board eligible or certified surgeons.

Tonsillectomies and adenoidectomies performed after a second opinion from an independent physician.

Dental orthodontic services required as therapy for handicapping malocclusion.

*Pregnant women—*

Services provided by a physician or by a physician extender under the supervision of a physician.

All professional services required during pregnancy and delivery.

All professional services required for the diagnosis and treatment of conditions related to pregnancy during the 12 weeks following the termination of pregnancy.

*Other services*

*Children—*

Home health services including homemaker services limited to 120 days annually, subject to a 10-percent coinsurance.

Laboratory diagnostic services.

Drugs prescribed to be taken for longer than 4 weeks.

Devices, appliances, and equipment, subject to a 10-percent coinsurance fee.

*Pregnant women—*

All laboratory diagnostic services required during pregnancy and during the 12 weeks following the termination of pregnancy.

All drugs prescribed during pregnancy and during the 12 weeks following pregnancy which are to be taken for longer than 4 weeks.

## D. Administration

A three-member Maternal and Child Health Board within the Department of Health, Education, and Welfare would be responsible for the administration of the program. The members of the Board would be appointed by the President with the advice and consent of the Senate. The responsibilities of the Board would include the formulation of regulations, the negotiation of reimbursement schedules for institutions and of fee schedules for practitioners.

A National Maternal and Child Health Advisory Council consisting of six consumers and four experts in maternal and child health would be appointed by the Secretary of Health, Education, and Welfare. The Council would advise the Maternal and Child Health Board on matter of policy and the operation of the program and would report to the Board and to Congress annually.

## E. Financing

The program would be financed through a maternal and child health trust fund. The sum of $100 million would be transferred from the Treasury to the trust fund for initial capitalization of the program. In addition, the trust fund would be funded by a 0.1 percent tax on employees' wages, on self-employed income, and on employers' payrolls up to the amounts subject to tax under the Social Security Act. In any year in which the payroll taxes collected are not sufficient to pay the cost of the program, the bill authorizes appropriations of funds necessary to carry out the program.

## F. PAYMENTS TO AND STANDARDS FOR PROVIDERS OF SERVICES

Institutional reimbursement would be made by a method of prospective reimbursement negotiated by the institutions with the Maternal and Child Health Board or their respective delegates.

Professionals furnishing covered services would have to agree to accept the amount specified in the fee schedule established by the bill as payment in full, and to provide the information the Secretary requires to verify the services furnished. The Board would approve a schedule for each fee payment area of amount of payment to be made for various covered services. Included would be a fee scheduled for the furnishing of individual services, a schedule of single amounts for the furnishing of prepaid pediatric care, and a schedule of single amounts for prepaid maternity care. Fee payment boards would be established in each payment area to develop fee schedules for submission to the national Board. These schedules would be based on the prevailing fees in the payment area, with certain adjustments, as of December 31, 1974.

Payments to dispensers of drugs or appliances would be based upon wholesale cost and a dispensing fee negotiated between the dispensers and the Maternal and Child Health Board or their delegates.

The bill contains specific standards for determining whether hospitals, pediatric units, obstetrical units, nursing homes, and home health agencies, and pathology laboratories qualify under the program.

Only hospitals with 1,500 deliveries a year in an urban area and 500 deliveries in a rural area will be approved as institutions for the maternity benefits of this program. The Board could waive this provision if it finds it in the best interests of the medical care of the pregnant women in the area.

Only hospitals with defined pediatric units of at least 12 beds and a 70 percent occupancy rate and with no restrictions on visiting hours for parents and guardians except as medically required would be eligible institutions for the pediatric benefits of this program.

## G. EFFECT ON OTHER GOVERNMENT PROGRAMS

The existing maternal and child health program, the medicare program, and the medicaid program are amended so that no payment could be made under those programs for furnishing of services which would be eligible for payment as a covered service under this bill.

## H. OTHER MAJOR PROVISIONS

Special additional benefits would be covered for individuals residing in medically underserved areas or who because of poverty, discrimination, or cultural barriers are determined by the Board to have a higher risk of infant and maternal morbidity than other individuals. The additional services to be covered include transportation to and from a person furnishing covered services, care of a dependent while services are being furnished, social outreach assistance, and other similar services as determined by the Board.

Families who are indigent would be exempted from the coinsurance fee.

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